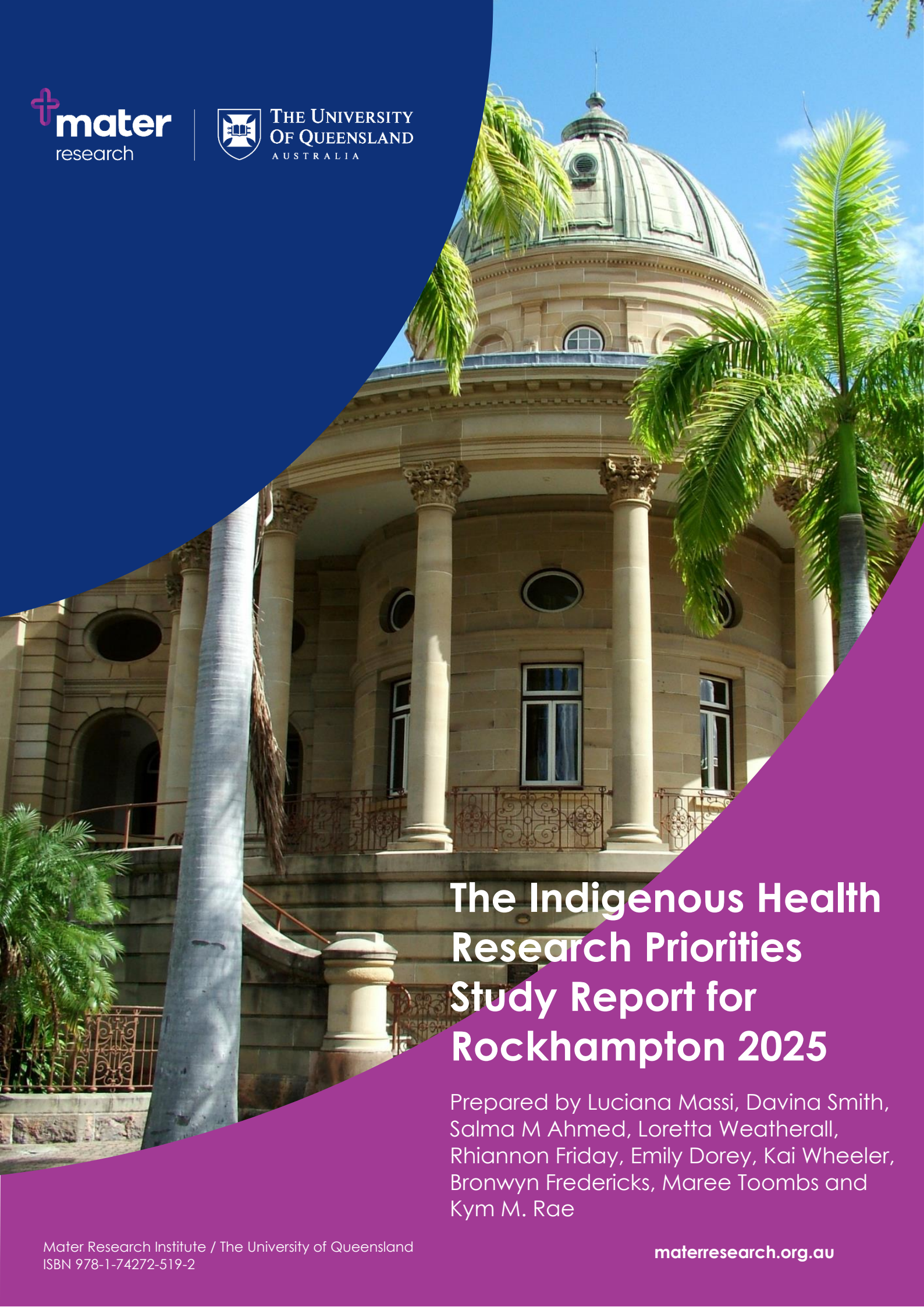




The Indigenous Health Research Priorities Study Report for Rockhampton 2025

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How to cite this report:

Massi, L, Smith, D, Ahmed, SM, Weatherall, L, Friday, R, Dorey, E, Wheeler, K, Fredericks, B, Toombs, M, and Rae, KM. (2025). *The Indigenous Health Research Priorities Study Report for Rockhampton 2025*. ISBN 978-1-74272-519-2. Mater Research Institute, South Brisbane, Queensland. DOI: <https://doi.org/10.14264/50683a9>.

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Acknowledgement

We acknowledge the Aboriginal custodians of the land on which we live and work across the greater Brisbane region, and the Aboriginal custodians of the lands where the study was conducted in Rockhampton (Darumbal people), Mt Morgan (Gaangulu people) and Emerald (Gayiri people), and pay our respects to their Elders past, present and future.

We are grateful to the participants - women, family members and health professionals who shared their stories, experiences, and aspirations for the health and wellbeing of their communities. This study was made possible with the support and partnership with Bidjerdii Community Health Services and the Central Queensland Hospital and Health Service. This includes the Chief Executive Officer, Marissa Smith, program managers (Kim Munns and Melina Fifita) and health services staff of Bidjerdii Community Health Services in Rockhampton, as well as Executives, managers and staff of Central QLD Hospital and Health Service (Gulam Khandaker, Donna Cruikshank, Ross Atu, Lucinda Nedwich), and Renee Williams previously from Queensland Aboriginal and Islander Health Council (QAIHC).

We acknowledge the Chief and Principal Investigators of the Strong Families Study who have contributed to the concept and co-design of the subsequent, future study based on the Queensland Indigenous Health Research Priorities Study: Prof Kym Rae; Prof Maree Toombs; Prof Roslyn N. Boyd; Prof Rhonda Marriott; Prof Sandra Eades; Dr Katherine Benfer; Dr Natasha Reid; Dr Koa Wittingham; Prof Robert Ware; Ms Tara Denaro; Ms Gail Wason; Dr Elizabeth Martin; Prof Vicki Clifton; Edwina Powe; Prof Leonie Callaway; Dr Gulam Khandaker; Prof Paul Robinson; Dr Kai Wheeler; Dr Emily Dorey; Dr Luciana Massi; Mrs Davina Smith; Ms Loretta Weatherall; Dr Salma M. Ahmed; Mrs Emma Kendall; Ms Rhiannon Friday.

Cultural Disclaimer

Aboriginal and Torres Strait Islander peoples are respectfully advised that this report may contain names, images or references to people who have passed. Such content may cause distress, particularly for the families and communities of the deceased person. Acknowledgement of image consent was verbally provided at time of yarning consultations.

Terminology

Throughout this report, the terms Aboriginal and Torres Strait Islander peoples and Indigenous are used interchangeably. The term Indigenous will be used more broadly to encompass Aboriginal and Torres Strait Islander peoples collectively, recognising the diverse cultures, histories, and identities that comprise Indigenous communities across Australia.

Acknowledgement of Funding

This work was made possible with the support of the Mater Foundation; particularly Equity Trustees (ANZ QLD Community Foundation, QCF ANZ Bank Fund, QCF - Thomas George Swallow Trust and the HJ Hinchey Charitable Trust). Professor Rae was awarded the Outstanding Women Researcher for Mater Research Institute which was used to support this project. The body of this work has been funded by NHMRC Clinical Trial and Cohort Scheme (GNT2023832) and undertaken as part of the co-design for the Strong Families Study.

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List of Abbreviations

ACCHS	Aboriginal Community Controlled Health Services
ADHD	Attention Deficit Hyperactivity Disorder
AHW	Aboriginal Health Worker
AMS	Aboriginal Medical Service
AOD	Alcohol and other Drug
ASD	Autism Spectrum Disorder
CQHHS	Central Queensland Hospital and Health Service
DOHaD	Developmental Origins of Health and Disease
FDV	Family and Domestic Violence
FAS/D	Fetal Alcohol Spectrum/Disorder
IRSAD	Index of Relative Socio-economic Advantage and Disadvantage
MIH	Maternal and Infant Health
NDIS	National Disability Insurance Scheme
PAR	Participatory Action Research
PHN	Primary Health Network
PICF	Participant Information and Consent Form
QAIHC	Queensland Aboriginal and Islander Health Council
SDOH	Social Determinants of Health
SEWB	Social and Emotional Wellbeing

Executive Summary

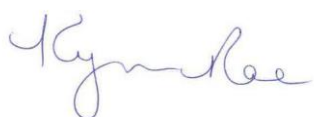
The Health Research Priorities Study aimed to engage with Aboriginal and Torres Strait Islander (herein respectfully referred to as Indigenous) communities in Queensland through a co-designed and collaborative process. The goal of this research study was to work in partnership with local Aboriginal community-controlled health services (ACCHS) to co-identify health research priorities for families and communities during the perinatal period. Certain themes which fell outside the perinatal period included general health concerns such as chronic diseases, and Elders health and wellbeing. It is hoped that these priorities can inform future health programs, services and research projects which have been chosen by communities.

Using a Participatory Action Research (PAR) approach, yarning sessions and Delphi workshops were held with clients and staff of health services in Central Queensland, specifically Bidjardii Community Health Services in Rockhampton and Mt Morgan sites, and Central Queensland Hospital and Health Services in Rockhampton and Emerald from October 2023 to October 2024.

This report presents findings from the yarning sessions and Delphi workshops, with the Top 10 health research priorities identified for each health service site, and overall, for Rockhampton communities. It also included participant demographic information, feedback on the research process and reactions to participating in 11 yarning sessions and the two Delphi workshops, involving a total of 95 participants. The qualitative analysis identified approximately 194 themes and subthemes based on initial yarning sessions. The themes were considered from a strengths-based perspective, focusing on the resilience and inherent strength of communities amidst the challenges faced.

Identification of health research priorities will support each Aboriginal community-controlled organisation and region of Queensland to develop research initiatives and the translational outcomes that are a focus for their community members. Recommendations for the direction of future studies include ensuring more wide-spread engagement with Rockhampton communities and reflecting on the most salient themes for the region to consider collaboration on future programs, services, and research.

This study has helped to inform the Strong Families Study, an Indigenous longitudinal pregnancy cohort study inclusive of mothers, partners and their children to be implemented in five Queensland regions. Through culturally responsive consultation, implementation and evaluation, the Strong Families Study will be tailored to each community, aiming to provide improved health outcomes throughout the lifetime of participants and within their community for generations to come.



Professor Kym Rae
Principal Research Fellow – Indigenous Health
Mater Research Institute

1. Background

Globally, there is widespread recognition among Indigenous people of the influence of past generations on the health and wellbeing of the current generation. The Developmental Origins of Health and Disease (DOHaD) concept addresses the relationship between early-life exposures, such as those from parents and grandparents or their environments, and the direct impact on their children (Gillman, 2005). For many Indigenous populations worldwide, DOHaD forms part of their worldview, traditional knowledge, and cultural practices (Martin & Mirraboopa, 2003). In Australia, Aboriginal and Torres Strait Islander (herein respectfully Indigenous) families are strongly bound through kinship and nurturing cultural practices that contribute to effective family functioning and child rearing (Arabena et al., 2016; Emerson et al., 2015; Lohoar et al., 2014). These practices have positively shaped children and communities across generations, including kinship relations, traditional knowledge systems, a collective community focus with respect for Elders contributions, and spirituality (Lohoar et al., 2014).

Indigenous cultural practices for health and wellbeing have always been present in communities, and include the interplay between Country, culture, and knowledge systems (Bywater & Fredericks, 2024; Fredericks et al., 2025; Martin & Mirraboopa, 2003; Tuhiwai Smith, 2021), including in Central Queensland (Fredericks & Bradfield, 2020, 2021). Biles et al. (2024) stated that the interconnectedness of cultural practices demands a holistic approach that is important to the health and wellbeing of Indigenous peoples. Connection to Country, culture and knowledge systems outlined in the Uluru Statement from the Heart infers that resilience and self-determination have the potential to revitalise health outcomes and health systems (Chamberlain et al., 2024; Langton & Stanley, 2023) Indigenous peoples' self-determination recognises long-held traditions of self-governed decision making (Australian Human Rights Commission, n.d.; UN, 2013). Investing in health programs and services that support Indigenous families, with a focus on mothers, fathers and babies is critical for impacting the life trajectories of Australia's Indigenous peoples (Bowes & Grace, 2014; Commonwealth of Australia, 2020; Mildon & Polimeni, 2012).

The First 1,000 days - from conception to two years of age, or the perinatal period - is widely recognised as a crucial period for establishing the foundations for nurturing healthy, thriving children into productive adulthood (Mildon & Polimeni, 2012; Millei & Sumsion, 2011; Pem, 2015). Consequently, many policies and services from health services and community-controlled organisations supporting Indigenous families focus on the period during pregnancy and early life stages (Commonwealth of Australia, 2020; Eades, 2004). This period spans from pregnancy to the end of the first year after birth (Austin et al., 2007). Research undertaken during the perinatal and early childhood periods is essential as it can potentially identify maternal health risks or negative health outcomes, and the benefits of certain actions, from the outset of a child's life (Austin et al., 2007; Marriott et al., 2019).

The 'Growing Deadly Families' (Aboriginal and Torres Strait Islander Maternity Services Strategy 2019-2025) written in partnership with the Queensland Aboriginal and Islander Health Council (QAIHC) states that 'nothing is more important than ensuring our future generations have the best start to life' and have called for Aboriginal and Torres Strait Islander people to be equal partners in 'decision-making, planning, delivery and governance' (Queensland Health, 2019, p. 21). National Indigenous leaders have highlighted that life-course focused research is a valuable mechanism for understanding the health of Indigenous peoples. However, such research must be led by or co-designed with Indigenous communities to ensure local research priorities are identified and addressed (Ewen et al., 2019). The National Agreement on Closing the Gap underscores the critical importance of ensuring Indigenous people have genuine opportunities to exercise self-determination in research. This includes the design and delivery of services that impact their communities. Such

engagement is essential for achieving better life and health outcomes for Indigenous communities (Commonwealth of Australia, 2020).

This significantly points to joint ownership in the research process and the solutions identified (Fredericks et al., 2011; Walker et al., 2014). Dudgeon *et al.* (2020) suggest that Aboriginal Participatory Action Research (APAR) focuses on key Indigenous paradigms that build self-determination in communities and contribute to the interconnectedness of Indigenous social and emotional wellbeing through knowledge systems and ways of knowing, being and doing (pg. 30). Additionally, the use of Delphi consensus techniques are appropriate methods for conducting APAR and have been previously used in Indigenous health research studies (Dale et al., 2021; Hart et al., 2009; Stearne et al., 2022; Stoner et al., 2017). The opportunity for participants to share their individual and collective stories contributes to the production of Indigenous knowledge, including the social and cultural determinants approach to evaluating APAR principles and approach, decolonising strategies and building collaborations to influence policy and programs (Dudgeon et al., 2019).

1.1 Aim

The Health Research Priorities Study aimed to engage with Indigenous communities across Queensland to identify health and medical research priorities for young families during preconception, pregnancy, post-partum, and childhood. The study sought to determine these for Indigenous women and men and their young family members during the perinatal and early childhood period through a co-designed and collaborative process.

The goal of this research study was to work in partnership with community-controlled sector and Indigenous communities using PAR approaches to co-identify research priorities for families and communities during the perinatal period.

2. Methods

2.1 Inclusion of Aboriginal and Torres Strait Islander People

Indigenous communities have played a crucial role throughout every phase of this study, ensuring that their perspectives and voices are deeply embedded in its foundation (Massi et al., 2023). Initially, preliminary face-to-face discussions were held with the Queensland Aboriginal and Islander Health Council (QAIHC) to determine if health service members would find the proposed study beneficial for their communities. QAIHC serves as the peak professional body for 31 Indigenous community-controlled health services in Queensland. With the support of QAIHC, continuous and regular meetings were established with identified services to foster the development of rapport and trust between the research team and the health services before the commencement of the study.

All research team members have been involved in determining the research aims, study design and data analysis. Most importantly, research partnerships were established with eight Indigenous community-controlled health services' Chief Executive Officers and Deputies across QLD, who have been instrumental in designing, planning and implementing the study. Establishing and maintaining relationships, as well as ongoing communication with Aboriginal community-controlled health services, have been essential for facilitating planning and processes to occur.

2.2 Collaboration with services

In the Rockhampton region, contact and approval to undertake the study were established with the Bidjerdii Community Health Services, and Central Queensland Hospital and Health Services (CQHHS - QLD Health). The study team met with key staff from both services who were supporting Indigenous families, particularly during the perinatal period (defined as pregnancy and the First 1,000 days of a child's life) (Arabena, 2014). To foster rapport building among research partners, face-to-face meetings were consistently held, underscoring the commitment of the research team to engage directly with services by travelling to the local region.

2.2 Study design with services

Relationship building and ongoing communication with Indigenous community-controlled health services were key to enabling planning and processes to occur and to manage the challenges of travelling to the regions. During initial face-to-face meetings with the services, the team discussed study approaches that they thought might be appropriate for Bidjerdii and CQHHS and sought advice about the suitability of this for local sites.

Various models of how the study could occur were also discussed between health service staff and research study team members. The team met with each service three times before the study began to discuss methods and approaches. These meetings also ensured that both the service and the research team had a clear understanding of each other's expectations and discussed each stage with the research team. Throughout this process, consultation with QAIHC, Senior Indigenous Academics and research team members ensured that community engagement, study protocol, data collection and analysis would respect Indigenous ways of knowing, being and doing (Martin & Miraboopa, 2003) and community expectations which the team needed to be aware of and utilised when and where appropriate.

Relationship building and ongoing communication with Indigenous community-controlled health services have been key to enabling planning and processes to occur when and where services are preferred. Various models of how the study could occur were also discussed between the service staff and members of the research project team. The team met with each service up to four times before the start of the study to continue to discuss methods and approaches and ensure that both the service and the research team had a clear understanding of expectations at each stage of the study.

2.3 Research team

This research team includes both Indigenous and non-Indigenous researchers.



Professor Bronwyn Fredericks is a Murri woman and Pro-Vice Chancellor of Indigenous Engagement and a Senior Indigenous Academic with a strong interest in women's health.



Professor Maree Toombs is a Euahlayi/Kooma woman and who also has a strong Indigenous research background, particularly in qualitative and translational research.



Ms Davina Smith is a Gooreng Gooreng and South Sea Islander woman with a rewarding career spanning across education and health care settings. Previously working in a strengths-based birthing service to support the health and wellbeing of families in South East Queensland, her leadership and expertise in working collaboratively places a focus on Indigenous communities' strengths and resilience.

Ms Loretta Weatherall is a Gamilaraay woman who has been involved in research with Aboriginal women during pregnancy and early childhood for many years. Prior to this project she was primarily involved in recruitment retention and Indigenous governance rather than data analysis.



Dr Kai Wheeler is a proud Ngarabal person who investigates how Aboriginal and Torres Strait Islander communities can co-design programs that build capacity and engage children and young peoples in a broad range of development areas.

Ms Rhiannon Friday is a proud Bwgcolman woman from Palm Island and also from the Kuku-Yalanji, Olkolo and Lamma Lamma from Far North Queensland. Rhiannon is a Research Assistant who supports the collection, analysis, and reporting of data to advance health initiatives focused on Indigenous communities.



Dr Luciana Massi is a postdoctoral qualitative researcher with 18 years' experience in research and teaching in public health, focusing on evaluating strengths-based programs to improve health, well-being and birthing outcomes for Aboriginal and Torres Strait Islander mothers, babies and families. Luciana was born in El Salvador and has lived in Australia for 36 years.



Dr Salma M Ahmed is a postdoctoral researcher with specialised expertise in quantitative research methods. Salma's background is in perinatal health, child development and environmental health. As a proud Somali woman, Salma is passionate about culturally responsive research that celebrates and amplifies diverse voices and drives meaningful change.

Dr Emily Dorey is Program Manager who is responsible for overseeing the implementation and strategic direction of initiatives aimed at improving health outcomes for Indigenous communities. Her expertise in building partnerships with stakeholders and managing diverse teams ensures the successful delivery of impactful health programs.



Professor Kym Rae is Professorial Research Fellow and Group Lead for Indigenous Health Research at Mater Research Institute. She is a non-Indigenous woman who has been working alongside Aboriginal communities for over 15 years. Building on her background in quantitative research in maternal infant health, she has prioritised and developed expertise in qualitative research, specifically in hearing the stories behind the data and working directly with communities. She has built these relationships predominantly in NSW and Queensland. As Lead Investigator on this project, Professor Rae contributed a high level of maternal health knowledge and leads several projects designed to hear the stories of those involved.



2.3.1 Researcher characteristics and reflexivity

Research data collection for this project was led by two Indigenous Researchers (LW* and DS*) and two non-Indigenous Researchers (KMR and LM). Additionally, a male Indigenous Researcher (KW*) led any research specific to Men's Business to ensure cultural sensitivity and consideration of topics identified, discussed or analysed. Each researcher has experience conducting qualitative interviews with Indigenous people and has over 15 years of experience in various research studies. Researchers worked closely throughout this project in all stages of data collection, analysis, and writing. Reflexivity in the research approach enabled flexible methods of generation, interpretation and analysis of data (Braun & Clarke, 2006). Indigenous research team members (LW*, DS*, MT*, BF* and KW*) ensured the voices of all Indigenous community members were privileged, confirmed the data analysis, and made sure reporting was trustworthy.

The senior research team have significant higher education, biomedical and research knowledge. It included one non-Indigenous Professor (KMR) with experience conducting longitudinal cohort studies with Indigenous mothers and babies, and two Senior Indigenous Professors dedicated to Indigenous health and education programs and evaluations (MT* and BF*). The research team met regularly to discuss and reflect on researcher assumptions, with cultural mentorship provided by MT* and BF*. Further KW*, a Senior Lecturer, provided additional academic and cultural mentorship for all research team members both while collecting data and while undertaking analysis and interpretation. Research team members collaborated to ensure data was collected (LW*, DS*, KMR, KW*, ED and LM), and analysed appropriately (LW*, DS*, KMR, KW*, LM, ED, SMA, MT* and BF*).

2.4 Study design

A qualitative research approach, using yarning methodology for focus groups and workshops, was undertaken in various regions of Queensland, Australia. While this report is focused on the outcomes

for Rockhampton specifically, it formed part of a larger Queensland study. Yarning methodology is an informal and relaxed discussion that informs, and exchanges knowledge with ongoing analyses and comprehensive understandings to promote advocacy in which both the researcher and participant journey together visiting places and topics of interest relevant to the research study; developing relationships that are accountable to Indigenous people participating in the research, and produces participants' stories about their lived experiences, feelings, thoughts and ideas on the research topic specific to Aboriginal and Torres Strait Islander peoples (Bessarab & Ng'Andu, 2010; 2018; Fredericks et al., 2011; Wain et al., 2016). Yarning is a culturally responsive way of collecting data with Indigenous community members and staff (Bessarab & Ng'Andu, 2010, 2018; Kennedy et al., 2022). Various types of yarns can be used in research, and include social, research and collaborative yarns (Kennedy et al., 2022). They are viewed as 'both a process and an exchange', involving 'elements of respect, protocol and engagement in individuals' relationships with each other' (Fredericks et al., 2011, p. 13).

The study involved two phases of data collection: Phase 1 consisted of a series of yarning sessions, followed by Phase 2, which involved a Delphi workshop. Following Phase 1, the research team conducted a thematic analysis and identified research priority themes derived from the yarning session data. This was followed by Phase 2, where a Delphi workshop was conducted to prioritise the research health themes identified by the community groups involved.

2.5 Study setting

2.5.1 Rockhampton sites

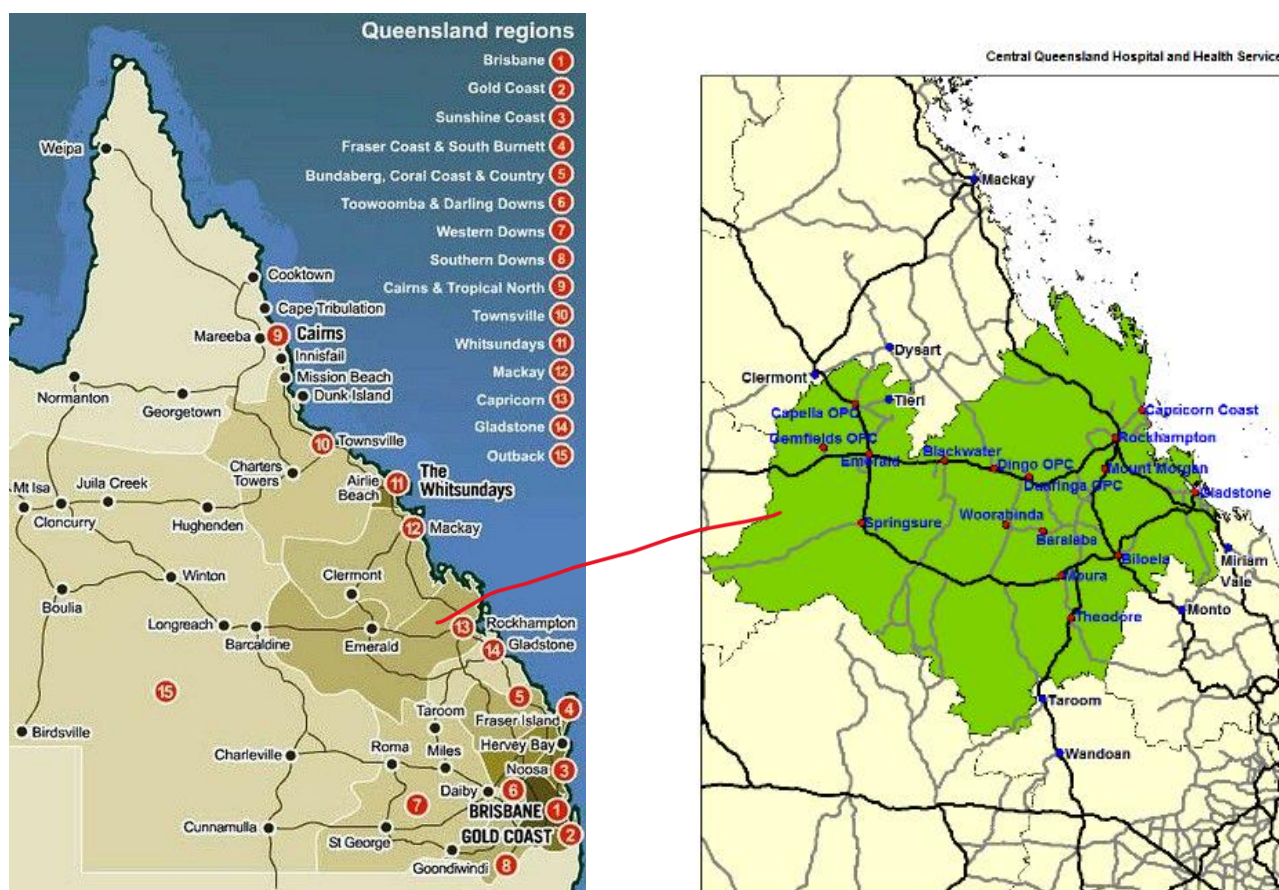
Rockhampton

Rockhampton is in the Central Queensland region, situated along the Fitzroy River, and located 42 km inland from Australia's east coast. As of the 2022 census, the population was 83,723 (Informed Decisions (.id) for Rockhampton Regional Council, 2022), with 8.7% identifying as having Aboriginal and/or Torres Strait Islander heritage (Informed Decisions (.id) for Rockhampton Regional Council, 2021a), significantly higher than that of regional Queensland. According to the Socio-Economic Indexes for Areas (SEIFA), which measures the relative advantage or disadvantage of an area, Rockhampton has a SEIFA index of 949 indicating that it is slightly below the national economic indexes (Informed Decisions (.id) for Rockhampton Regional Council, 2021b). However, similar to other larger towns, there are areas of both extreme disadvantage and affluence.



Source: [*Insider's Guide to Rockhampton | Travel Insider*](#)

In the Rockhampton region, this study has partnered with Central Queensland Hospital and Health Service (CQHHS), Bidgerdii Community Health Service and Yoonthalla Services Woorabinda. Central Queensland Hospital and Health Service provides health care services to the region, including Gladstone, Emerald and Biloela, with Rockhampton Hospital being its largest facility. The Bidgerdii Community Health Service is community-controlled and has been providing primary health and social and emotional wellbeing programs and services across the lifespan for over 30 years to Aboriginal and Torres Strait Islander peoples in Rockhampton and Mount Morgan. The Rockhampton Children and Family Centre run by Bidgerdii, focuses on programs and services in the First 1,000 Days initiative (Arabena, 2014; Arabena et al., 2016), and partnered with our research team to undertake this study from 2023.



Source: qld.gov.au

Figure 1 Map of the Rockhampton region in Central Queensland, displaying the CQHHS and Bidgerdii Community Health Service.

2.5.2 How this study fits with wider QLD sites

This study in Rockhampton is part of a broader program of work from multiple sites across Queensland. Woorabinda is another Central Queensland site, with a separate report is being prepared. Further study sites include Townsville, Palm Island, Darling Downs, Far North Queensland, and Woorabinda. The outcomes report from Far North Queensland (Rae et al., 2023), Darling Downs (Massi et al., 2024), Townsville (Smith et al., 2025) and Palm Island (Wheeler et al., 2025) have been published and disseminated to partner services.

Woorabinda

Woorabinda is made up of a small community that is located approximately 170 km from Rockhampton. It has a population of 962, with 94.7% of the community identifying as having Aboriginal and/or Torres Strait Islander heritage (Australian Bureau of Statistics (ABS), 2016). Woorabinda is considered a young community with 33.2% of the population aged under 14 years of age. According to the 2021 SEIFA, Woorabinda, with a score of 659, is in a growth state, with much potential in its community resources, people and solutions-focused approaches. The results for the Woorabinda community will be reported separately at the request of the community. Both the Central Queensland Hospital and Health Service and Yoonthalla Services Woorabinda provide health and social support services to the Woorabinda community. The Woorabinda Multipurpose Health Service offers acute inpatient and outpatient care, as well as access to visiting specialists.

Townsville

As of 2021, the population of Townsville had reached 192,768 people and has shown consistent growth over the years (Informed Decisions (.id) for City of Townsville, 2021). In the same year, 16,271 individuals (8.4% of the community) identified they were of Aboriginal and Torres Strait Islander heritage which is well above the expected 6.1% in regional areas of Queensland. The Townsville City community had the highest level of economic advantage with a SEIFA score of 1065.1 compared to the Bohle Plains area which had the lowest with a score of 1076.3 for Townsville communities.



Source: alchetron.com and qld.gov.au

The Townsville Aboriginal and Islander Health Service (TAIHS) was established in 1974 and is a large community-controlled health service that aims to deliver culturally responsive services to support Aboriginal and Torres Strait Islander people in the Townsville region. It provides important social support services, including housing, family support, youth services, and assistance with domestic and family violence issues (TAIHS, 2024). TAIHS partners with the Deadly Choices program and provides accommodation services, playing a significant role in addressing health disparities and promoting health equity for Aboriginal and Torres Strait Islander communities. The health service collaborates closely with local hospitals, governments, and other service providers, integrating traditional knowledges with mainstream healthcare practices to ensure culturally safe as well as comprehensive care and support. For this study, the research team worked closely with the Maternal and Child Health, Family Wellbeing and Medical Services teams in TAIHS.

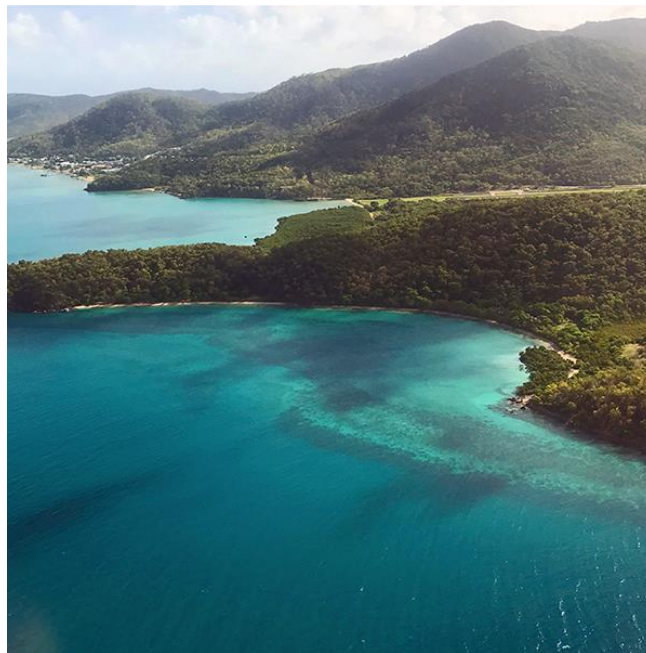
Townsville Hospital and Health Service extends its services to 21 facilities, 19 hospitals and two residential aged care facilities (Queensland Government, 2023). It is the only tertiary referral centre in North Queensland and serves as a hub for health research in the region. The hospital delivers medical care to patients from across North Queensland, extending to the Cape York Peninsula, Torres Strait Islands, Mount Isa, and the Gulf of Carpentaria. It offers comprehensive services across key medical specialties, including cardiothoracic, gynaecology, neurosurgery, orthopaedics, oncology, among others. The research team worked with Midwifery within the Health and Wellbeing Service Group, and Early Child Health teams for Phase 1 of this study.

Palm Island

Palm Island is a beautiful tropical island located off the coast of Townsville. This small island region consists of approximately 12 islands with just over 2,000 people, and the majority of the population

residing on Greater Palm Island (Australian Bureau of Statistics (ABS), 2021). While its population is reported at around 2,000 this can swell to 4,000 during community events on the island. There is a high mobility of residents between Palm Island and the mainland. Most of the population (91.4%) in Palm Island consists of Aboriginal and/or Torres Strait Islander families.

The Palm Island community experiences profound disadvantage with a SEIFA index of 533.8 (Informed Decisions (.id) for Regional Development Australia, 2021). Palm Island Community Company is an Indigenous community-controlled service and provides a range of health services, community enterprises, haven services, and social and emotional wellbeing support. On Palm Island, the study has partnered with Palm Island Community Corporation (PICC). The Townsville Hospital and Health service also provides health services to the Joyce Palmer Health Service and the Palm Island Care Centre on Palm Island. These services are available for all emergencies and provides hospital level care for non-critically ill patients of the islands.



Source: ican.org.au

Far North Queensland sites



Source: APS Member Groups: Far-North Queensland

Three ACCHS in Far North Queensland are partnered as participant sites for the study: two in Cairns (Wuchopperen Health Service and Mookai Rosie Bi-Bayan) and one in Mareeba (Mulungu Aboriginal Corporation Primary Health Care Service).

Wuchopperen Health Service is the largest ACCHS in Cairns, delivering culturally appropriate and comprehensive primary health care, which includes medical, social and emotional wellbeing services for Aboriginal and Torres Strait Islander peoples (Wuchopperen Health Service, 2022). It provides continuous care during ante- and post-natal stages, including referrals and liaising with other health agencies and services. Additionally, it offers the Australian Family Partnership Program, a family partnership worker and nurse-led home visiting program for first-time mothers (Wuchopperen Health Service, 2022). Wuchopperen has around 190 staff, with approximately 60% identifying as Aboriginal and/or Torres Strait Islander.

Mookai Rose Bi-bayan is a community-controlled organisation, with a majority of Indigenous staff members including health professionals, catering staff, receptionists, program and administrative staff, and drivers. It is a friendly, comfortable, and culturally appropriate residential health care facility for women travelling from the Torres Strait Islands and Cape York Peninsula during pregnancy and birthing of their baby in Cairns. Women can stay during pre- and post-natal periods, as well as receive other health care needs across the lifespan. Mookai Rose Bi-bayan can accommodate up to 24 clients, where women can feel safe and secure while spending early days bonding with their new baby or recovering from medical treatment" (Mookai Rosie Bi-bayan, 2020). Also provided are transportation, meals, weekend outings for shopping, and other activities such as fishing, arts, and crafts, and attending cultural events.

Mareeba Shire is located on the Atherton Tablelands, 64 km southwest of Cairns, and has varied landscapes including World Heritage rainforest, waterfalls, agricultural farms, and cattle properties. Mulungu Aboriginal Primary Health Care Service (Mareeba) provides community-controlled and culturally appropriate primary health care across the life course, including clinical and social support to Indigenous families (Mulungu Aboriginal Corporation Primary Health Care Service, 2022). Mulungu

has 80 staff with 95% identifying as Aboriginal and Torres Strait Islander (Mulungu Aboriginal Corporation Primary Health Care Service, 2022).

Darling Downs

In 2022, the Darling Downs region became a further site for the Indigenous Research Priorities study (Massi et al., 2024). This work focused on Carbal Medical Service which has clinics in Toowoomba and Warwick. Carbal Medical Service was established in 2002 to improve access to a culturally appropriate and community-controlled responsive medical service across Toowoomba and Warwick, offering parenting programs including "New Directions: Mums & Bubs program", "Strong Mothers" and "Strong Fathers, Strong Families" programs (Carbal Aboriginal Medical Service, 2022).

Toowoomba and its surrounding areas have a strong agricultural industry and are considered to be in the third quintile in the IRSAD (Australian Bureau of Statistics, 2016). It has a population of 162,054, with 4.8% identifying as Aboriginal and/or Torres Strait Islander. Warwick is a smaller regional town located one hour south of Toowoomba with a population of 12,294 in the 2021 Census. However, the Aboriginal and/or Torres Strait Islander population is approximately double that of Toowoomba, making up 8% of the population (Australian Bureau of Statistics, 2021b).

2.6 Participants and recruitment

2.6.1 Participant characteristics

As this study has focused on families during the perinatal period it was important to include: 1) Indigenous community members, especially pregnant women, mothers, fathers, family members, kinship carers and Elders; and 2) health care professionals who work in maternal and infant, and early childhood health roles that support families during this time of life. Each service identified that their health service staff were often Aboriginal and Torres Strait Islander people and/or they had significant experience in the areas of health research needs for their communities.

We respectfully acknowledge that many Indigenous health professionals are also members of the local community. Many of these staff have generously shared their personal stories as much as they have shared their professional knowledge. With input from our partner organisations, we included participation from other health workers from different areas of a health service who would like to be involved in any aspect of the study, as we understand they are also community members and may want to share their insight on health priorities in their communities.

2.6.2 Recruitment and consent

Working with our partnered ACCHS and hospital and health services, we identified a study champion at each service to assist in planning the study visits with the research team. The Participant Information and Consent Form (PICF) was sent to the study champion prior to focus groups to familiarise themselves with the study. All participants (health professionals and community members) were provided with information about the study before attending on the day. Key health service contacts were encouraged to promote the yarning groups around their services via promotional flyers provided by the research team.

Each site chose to hold separate focus groups for i) health service staff, and ii) community members. The study champion arranged the timing of yarning groups with staff members to ensure that key service contacts were available to attend. At some sites, focus groups were scheduled during staff meetings to avoid disrupting routine health service delivery. Community members, especially mothers, babies, family groups, and Elders/Grandmothers groups, were invited by the health services to participate.

At the beginning of the sessions, the research team allocated time to explain the study, data management, and consent. Participants were informed that participation was voluntary and that they could withdraw at any time without affecting their care, their relationship with staff, or the services they were accessing. The groups were advised that sessions would be audio recorded and that their anonymity would be preserved at time of analysis, writing, and dissemination of results. Field notes would be taken by facilitators/researchers throughout the yarning session to aid in analysis.

Written informed consent was obtained before the start of the yarning sessions. It was also explained that future data could be kept by the community and/or service as the data custodians/owners. Participants could choose this option when giving their consent.

2.7 Data processing and storage

Yarning sessions were audio-recorded and transcribed verbatim. Transcripts and audio files were de-identified and saved as password protected files on a shared drive accessible only to the research team. Transcripts were imported into NVivo 12 software for analysis (QSR International, Melbourne, 2012). Following thematic analysis (Braun & Clarke, 2006) to identify recurring themes from the yarning transcripts, Delphi workshops consisted of participants prioritising the health themes to identify health priorities for communities.

2.8 Data ownership

Data, including surveys and voice recordings arising directly from participants remains the property of the participant however analysis from the data is owned by the research team. The data generated from the research study is managed according to ethics approvals and the University's Research Data Management Policy. This policy was developed to ensure that research data is ethically managed according to recommendations made in The Australian Code for the Responsible Conduct of Research and applicable legislation.

2.9 Ethics

This study and its methods were designed to meet the ethical guidance from the Australian Institute of Aboriginal and Torres Strait Islander Studies (Australian Institute of Aboriginal and Torres Strait Islander Studies, 2020). The study was approved by a Hospital Human Research Ethics Committee (HREC/MML/72562 (V3)) and ratified by one university Human Research Ethics Committee (2022/HEO01885).

Participants were reimbursed with a AU\$30 gift voucher from a department store or supermarket as a token of appreciation for their time and contribution. Before the study, various options were

discussed with partner services, and it was determined gift vouchers for a local department store or supermarket were highly valued by participants.

2.9 Data collection

Data for this study was collected in two different phases (Phase 1 and 2).

2.9.1 Phase 1: Focus groups/yarning sessions

After signing consent forms, participants completed a brief survey to gather demographic information, including age, gender, number of children, education, employment status and income. The survey was developed in collaboration with our site champions during earlier health services visits, and proposed recommendations by key health care staff were incorporated to enhance the clarity of the questions.

Upon arrival, participants were greeted by the team and offered a choice of drinks and food. The participants enjoyed these refreshments as they completed the initial surveys and engaged in informal, friendly conversations with researchers. The research team discussed casual topics such as recent news and events, weather, and asked about local sites. Yarning was conducted face-to-face in meetings or training rooms at Indigenous community-controlled health services or the hospital and health service.

The yarning session commenced with an Aboriginal researcher (LW* or DS*) delivering an Acknowledgement of Country¹ (University of Queensland, 2023). If an Elder was in attendance, they were asked if they would like to do this as a mark of respect for their cultural seniority. This was followed by a social yarning approach where each researcher/facilitator gave a short self-introduction (LW*, LM, KMR and KW*). They shared details about their non-research backgrounds, including their upbringing, community connections, family lives, and their interest in this work to build trust and connection. By utilising a social yarn in the beginning, researchers were able to build rapport and make participants feel at ease, which facilitated the sharing of their own stories during the subsequent open discussion (Bessarab & Ng'andu, 2010).

Following this, the session transitioned to the research yarn, which included a brief overview of the background and rationale for the study (Kennedy et al., 2022). A yarning tool was used to guide participants through discussions, while also providing a visual aspect to the yarning topics (Figure 2). The provision of tools as visual prompts has proven effective in other qualitative studies involving yarning sessions with women and community members (Kennedy et al., 2022; Massi et al., 2023). Thus, the tool used in this study outlined the topics to be covered during the yarn, including young family's health needs, health issues affecting families/communities and services available. These tools were printed, distributed around the room, and introduced by researchers to allow participants to engage in yarns about the outlined topics when they were ready (Kennedy et al., 2022).

¹"An Acknowledgement of Country is an opportunity for anyone to show respect for Australia's Traditional Custodians, and the continuing connection that Aboriginal and Torres Strait Islander peoples have to the land, sea, sky, and waterways. An Acknowledgement of Country can be performed by an Aboriginal, Torres Strait Islander or non-Indigenous person, and is generally offered at the beginning of a meeting, speech, or formal occasion." (University of Queensland, 2023)



Figure 2 Yarning tool used during Phase 1 yarning sessions

2.9.2 Phase 2: Delphi study

During Phase 2, the research team (DS*, LW*, LM and ED) employed a PAR approach, returning the findings to communities and facilitating community member participation in a workshop to reach consensus on priorities through a Delphi study (Keeley et al., 2016). Three-hour workshops with health care staff and community members were organised through the services. While it was encouraged, the same participants from the initial focus groups didn't need to attend these workshops. This workshop could be conducted with health service and community members simultaneously, although the arrangement was left to the discretion of the health service team. For new participants joining the study in Phase 2, the recruitment and consent processes outlined in Phase 1 were followed.

The thematic analysis from Phase 1 yielded strong themes, sub-themes and at times sub-sub themes, which were incorporated into the Delphi workshops (see Appendix 2). The Delphi workshops began with the research team presenting the identified themes from Phase 1 to the community through digital or printed slides, ensuring each participant clearly understood the meaning of each theme. Community members were given time to ask questions and make comments during this part of the session.

The Delphi component of the workshop was conducted in several "rounds" to encourage engagement and discussion. Participants were seated around tables, with themes presented on cards resembling playing cards. Each participant had their own set of 'theme playing cards' in front of them (Figure 3). In Round 1, the research team aimed to have participants halve their playing cards by categorizing them as either 'yes' (important to me) or 'no' (not important to me). For example, if there were 100 playing cards at the start of Round 1, participants would be asked to reduce this to 50 themes that were important to them.

The researchers then tallied the 'yes' votes for each theme on a whiteboard or butcher's paper for everyone to see, and the top two-thirds of themes were used again in Round 2. The final score of each theme was the sum of the scores of all participants. The bottom third of themes were discarded, with a researcher ensuring each participant had only the agreed-upon theme cards in front of them.

for the next round. Delphi surveys are conducted over multiple rounds, typically between four to six, or until sufficient consensus was reached (Cantrill et al., 1996). Due to time constraints, only two rounds were conducted during the Phase 2 workshops, with the goal of identifying the Top 10 priority areas.



Figure 3 Researchers Loretta Weatherall and Davina Smith visiting a youth community event at Rockhampton Leagues Club, Browne Park.

2.9.3 Feedback forms: assessment of acceptability and feasibility of study approach

Participant feedback forms were distributed at the end of Phase 1 and Phase 2 to evaluate participants' satisfaction and experience of the topics covered during the yarning session and Delphi workshop in the research study. The feedback form consisted of five open-ended questions, which asked about the best aspects of the yarning sessions, what words or feelings came to mind about participating in the sessions, suggested improvements, and other comments.

A brief thematic analysis was undertaken depicting results in Word clouds. In this approach, all survey question responses were loaded into the appropriate software (Nvivo 12 QSR International, Melbourne, 2012) and a Wordcloud was generated for each survey question. Words that appear more frequently in the survey responses were displayed larger and bolder while less common words were smaller.

Questions asked were:

1. Name the things you enjoyed the most about taking part in today's session (either yarning session or Delphi workshop)?
2. Is there anything we haven't touched on today that you would like us to know?
3. Were the topics covered today relevant to you?
4. What words or feelings come to mind when you think about what we've talked about today?
5. Is there anything we could change or improve about today's session?

Figure 4 Questions from the Research Feedback for participants

2.10 Data analysis – Phases 1 & 2

2.10.1 Identification of health research priorities list

Following transcription, the research team reviewed audio recordings and transcripts to ensure accuracy. Three researchers (DS*, LW* and LM) conducted an initial thematic analysis, reading and then re-reading of the focus group transcripts, using open coding to identify broad themes directly from the data (Kitto, et al., 2008). Through inductive coding, main themes and subthemes were identified and an initial coding framework was created. These themes were also discussed, refined and confirmed with Senior Indigenous researchers (BF*, MT*) who reviewed a selection of the transcripts. NVivo 12 software (QSR International, Melbourne, 2012) was then used to code the data and generate coding trees throughout various stages of analysis.

A six-step process was followed for data coding and analysis: 1) immersion in the data (including a review of transcripts and audio recordings for accuracy and editing as needed) repeated active reading/viewing); 2) generation of initial codes; 3) searching for themes; 4) collaboratively reviewing themes; 5) collaboratively defining and naming themes; and 6) producing the report including data extracts (Braun & Clarke, 2006).

Harnessing the voices of Indigenous women, men, families, and staff to determine community health research priorities was essential for the thematic analysis of yarning group transcripts. Thematic analysis revealed a range of themes based on data collected during yarning sessions to determine health research priorities for young families in communities. However, other themes that fell outside of this aim were at times identified. Health research topics that were beyond the scope of our study were included in the prioritisation exercise; and as requested by services, a connection could be facilitated between participating health services and other research teams focusing on these research topics.

As themes were extracted from the data, a second review was undertaken by all research team members collaboratively. This process assisted in forming the basis for a list of health research priorities to be used in the Delphi workshop. The purpose was to consolidate the identified health research priorities, ensuring that the theme names were extremely clear and finalised to prepare the theme cards for Phase 2. A key aspect of preparing for Phase 2 was to ensure that each theme had a clear and simple name with an unambiguous definition attached.

2.12.2 Analysis of Delphi workshops

Following data collection from Delphi workshops across all Rockhampton sites, the research priorities from each site were analysed to identify any differences between services within the region. In future, there is potential for comparisons between different regions, for example, between Far North Queensland (Cairns and Mareeba) and Tropical North Queensland (Townsville and Palm Island). It is anticipated that sites within regions may share the same research priorities. However, we acknowledge that each community has its own unique identity and may have areas of importance specific to them, which will require equal weighing in future research protocols.

3. Results

Between October 2023 and October 2024, the research team conducted yarning sessions and Delphi workshops in four sites in the Rockhampton region: five visits to Bidgerdii (Rockhampton and Mt Morgan), three visits to the CQHHS (Rockhampton and Emerald), and one visit to a community organisation, Girls Time Out. During this time, nine Phase 1 yarning sessions with 69 participants were held. In Phase 2, the two Delphi workshops had a total of 26 participants from both Bidgerdii and CQHHS teams. In some cases, a participant attended both Phase 1 and Phase 2 (See Appendix 1 for diagram of study visits).

Phase 2 Delphi workshops needed at least ten participants for the analysis to be meaningful. Therefore, Delphi workshops were only held at larger Rockhampton health service locations as the limited number of participants and local resources in smaller sites were unavailable to organise a larger group. Therefore, sites of Emerald and Bidgerdii in Mt Morgan, had only one visit to each location during Phase 1. Similarly, there was engagement with CQHHS in Blackwater, with initial interest expressed from staff, however competing priorities and reduced staff numbers meant Phase 1 yarning sessions were unable to be organised in the designated time.

Engagement of participants and promotion of the study was undertaken by various staff members from health services at each site, and the research team were grateful for the time spent by all sites to support this study. Each site encouraged its own staff to attend the workshops, and the input of staff was excellent and highly valued. The passion and dedication demonstrated by staff for their communities and clients was commendable.

3.1 Demographic of participants

As shown in Table 1, most Phase 1 participants were female (87%), less than 50 years of age (56.4%), and approximately 62.3% identified as Aboriginal, while only 2.9% identified as Torres Strait Islander and 2.9% of participants identified as both Aboriginal and Torres Strait Islander. A high proportion of participants were single (44.9%), and a small proportion were separated or divorced (7.2%), with 30.4% of participants having between 3 to 5 children and 14.5% caring for non-biological children. Less than half of the participants (47.8%) had post-school education. Income was widely distributed, with participants reporting income levels ranging from \$28,050 to approximately \$124,000 per year, with a median income range between \$49,901 - \$81,450. Sixteen participants identified themselves as community members, 14 as health care professionals, and 20 as workers in organisations or in

policy and practice. We note that many health care professionals, and workers in policy and practice also identify as community members.

Similarly, most participants in Phase 2 were female (96.2%) and were in the 40 – 49 years (26.9%) age group. Participants identified as Aboriginal (65.4%), Torres Strait Islander (7.7%), both Aboriginal and Torres Strait Islander (3.8%) or other cultural groups (23.1%). Many of the participants of Phase 2 had completed post-school education (57.7%) and were employed (73.1%). A high proportion of participants had 3 – 5 children (53.8%), and only 15.3% of participants were caring for non-biological children.

Table 1 Participant demographic characteristics

Demographic characteristics (n=98)		Phase 1 n=69 %		Phase 2 n=26 %	
Age range (years)	20 – 29 years	2	2.9	0	0
	30 – 39 years	13	18.8	2	7.7
	40 – 49 years	15	21.7	7	26.9
	50 – 59 years	9	13.0	6	23.1
	60 – 69 years	10	14.5	5	19.2
	70 – 79 years	9	13.0	4	15.4
	80 – 89 years	7	10.1	2	7.7
	Missing	2	2.9	0	0
Identity	Aboriginal	43	62.3	17	65.4
	Torres Strait Islander	2	2.9	2	7.7
	Aboriginal and Torres Strait Islander	2	2.9	1	3.8
	Other	19	27.5	6	23.1
	Missing	3	4.3	0	0
Gender	Female	60	87.0	25	96.2
	Male	9	13.0	1	3.8
	Missing	0	0.0	0	0
Marital Status	Single	31	44.9	10	38.5
	Married	15	21.7	10	38.5
	De facto	11	15.9	4	15.4
	Separated	4	5.8	1	3.8

	Divorced	1	1.4	0	0
	Widowed	4	5.8	0	0
	Missing	3	4.3	1	3.8
Number of children	Nil	14	20.3	3	11.5
	1 – 2	29	42.0	8	30.8
	3 – 5	21	30.4	14	53.8
	>5	5	7.2	1	3.8
	Missing	0	0.0	0	0
Number of dependants who are not biological children	Nil	59	85.5	22	84.6
	1 – 2	6	8.7	3	11.5
	3 – 5	4	5.8	0	0
	5 – 10	0	0.0	1	3.8
	Missing	0	0.0	0	0
Education	Less than high school	16	23.2	3	11.5
	Completed high school	16	23.2	8	30.8
	Some post-school education (TAFE, apprenticeship, university)	33	47.8	15	57.7
	Missing	4	5.8	0	0
Employment	Unemployed	8	11.6	3	11.5
	Employed	41	59.4	19	73.1
	Stay at home parent	8	11.6	1	3.8
	Retired	3	4.3	1	3.8
	Disability	6	8.7	2	7.7
	Missing	3	4.3	0	0
Role/s in community *(n=6 respondents in Phase 1 and 2 indicated they are a community member as well as their professional role)	Community member	16	23.2	8	30.8
	Health care professional	14	20.3	6	23.1
	Worker in organisations	8	11.6	12	46.2
	Worker in policy and practice	12	17.4	0	0
	Other	9	13.0	0	0

	Missing	10	14.5	0	0
Household income (annual)	\$0	1	1.4	1	3.8
	< \$28,050	5	7.2	4	15.4
	\$28,051 - \$49,900	9	13.0	6	23.1
	\$49,901 - \$81,450	17	24.6	5	19.2
	\$81,451 - \$124,600	9	13.0	0	0
	>= \$124,601	4	5.8	3	11.5
	Social assistance	5	7.2	3	11.5
	Don't know	3	4.3	3	11.5
	Prefer not to say	9	13.0	0	0
	No answer	1	1.4	1	3.8

3.2 Acceptability and feasibility of study approach

After the yarning sessions, the research team immediately reviewed participant feedback responses regarding the study's acceptability. This was undertaken to assess whether the research methods were deemed suitable as well as to gauge participants' satisfaction with the research process.

Of the 95 workshop participants during Phases 1 and 2, 82 participants completed the feedback forms. Responses indicated that the overall participation in the focus groups/yarning sessions was positive for most participants. Figure 4 highlights that when asked "what they enjoyed most about the focus group", predominant answers included the 'open and honest discussions', being able to listen and understand, to yarn, to learn', with one participant expressing they enjoyed the 'interaction' and 'getting together and yarning about all health services that our families can access for health and wellbeing'. However, some participants commented on the realisation that they felt 'sadness for the community', it made them 'concerned', 'disappointment' and highlighted the 'need for change'.

Phase 2 feedback included participants reporting they 'enjoyed seeing the priorities that came out of the last workshop and the challenge of only picking a specific number of health priorities for their communities. Another participant added that the 'workshop was appropriate, fun & informative' and they enjoyed the 'collaborative approach in unpacking what is needed for our community'

Themes and sub-themes were returned to each site and used as the basis for the Phase 2 Delphi workshop. Each service undertook the Phase 2 Delphi study to prioritise these accordingly for their service and community. Each Delphi workshop was conducted over several rounds to reduce the larger number of themes down to the top 10 priorities for the service. Data from the individual services will be reported in Sections 3.4 to 3.6.

In these results, the language chosen reflects the language used by participants, and we recognise that different language may have been used for similar themes chosen by the different services. For example, the key theme of Social Determinants of Health (SDOH) was sometimes referred to as that overall, however it was also expressed as separate themes which form part of the SDOH, for example 'housing', 'education', 'finance', and 'transport'.

Once each service had completed their Delphi study, the research team met with a small group of Chief Executive Officers and Managers from around Rockhampton, from both Bidjerdii and Central Queensland Hospital and Health services. This group also undertook a Delphi study to consider the priorities from a leadership perspective. Where there was consensus on themes, these were reported as priorities for that region. The table below indicates the priority theme and the number of services that identified it. The themes of 'Aboriginal community-controlled health services – holistic health and health across the lifespan' and 'health education and parenting programs', were examples of key themes that were consistently agreed upon by services and executives as being important priorities.

Table 2 – Health Priorities as identified by three health care services/groups

	THEMES identified	Number of services in agreement
1	Aboriginal Community Controlled Health Services (ACCHS) and Holistic health – health across lifespan; children's to Elders	3 - QLD Health & Bidjerdii CFC; Elders
2	Health education; parenting education & programs	3 - QLD Health & Bidjerdii CFC; Elders
3	Strong culture for health	2 - QLD Health & Bidjerdii CFC
4	Barriers to health services access	2 - QLD Health & Bidjerdii CFC
5	Family & domestic violence; systemic neglect	2 - QLD Health & Bidjerdii CFC
6	Diagnosis requiring early intervention	2 - QLD Health & Bidjerdii Elders
7	Chronic disease	2 - QLD Health & Bidjerdii Elders
8	Youth support & programs	2. QLD Health & Bidjerdii Elders
9	Mental health & trauma- informed training; grief and loss; social emotional wellbeing	2 - Bidjerdii CFC & Bidjerdii Elders
10	Social determinants – transport support	1
11	Challenges using mainstream health services	1

Following on from Phase 1, 26 participants completed a Delphi study that identified their top priority research areas. Full details of these themes are explored in the following sections for each service.

It is worth noting that there is considerable overlap between comments from participants contributing during the yarning sessions, therefore we have included the comment that best expresses a theme, feeling or idea. For example, a participant may discuss accessing dental checks for children and how that is an important parental responsibility. Therefore, this comment could be relevant in a discussion about parenting but also in the theme of accessing services.

Please note that comments have been attributed to:

1. Staff member/s
2. Community member/s

Results include quotes attributed to Central QLD Hospital and Health Service staff members based at Emerald who participated in the Phase 1 yarning sessions only. Due to the limited availability of staff and clients of CQ Health in Emerald, we were unable to conduct Phase 2 Delphi workshops in Emerald. Whilst we were unable to determine health priorities particular for Emerald, we recognise many of the health themes mentioned for Emerald aligned with those mentioned for communities in Rockhampton.

Similarly, yarning interviews were conducted individually with two community/staff members of non-government agencies, which have been included as and when relevant to the key themes highlighted.

3.4 Results Phase 1 & 2

3.4.1 Combined priority themes for Central Queensland Hospital and Health Service, Bidjerdii Elders Groups and Rockhampton Children & Family Centre (Bidjerdii)

There are several themes that were identified by all groups - Central QLD Hospital and Health Service, Bidjerdii Elders Group and Rockhampton Children & Family Centre (Bidjerdii). These are i) Aboriginal community-controlled health services and Holistic health and ii) Health education – parenting education and programs.

Aboriginal Community Controlled Health Services (ACCHS) and Holistic Health; Health Education - Parenting Education & Programs

3.4.1.1 Aboriginal Controlled Community Health Services (ACCHS) and Holistic health

Holistic health encompasses health across the lifespan, which is the cornerstone of Aboriginal and Torres Strait Islander health care. Holistic health was promoted and delivered through Aboriginal Community-Controlled Health Services (ACCHS). Community members viewed ACCHS as a service

that provides holistic, culturally safe and responsive healthcare. ACCHS were often regarded as a 'one-stop shop' caring for Mob, providing services such as social-emotional and health education programs, health checks, and counselling programs. Clients engaging with health services and programs was a key factor that contributed to actively building trust with health services.

Yeah, because Aboriginal people, they [don't like going] to the hospital. (Staff member, Bidgerdii, October 23)

P1: They still have the Ngua Gundi program. But hello, it's in the Community Health Building. Who's going to walk into a building like that? When we had our houses just up the road here, and it was homely. They all come because it was homely. And it's a house. And it was full of us Indigenous... Workers.

P2: Yeah. That's what we were telling you the other day. We all went back. And how they're all on the mainstream now. Not the same. Not the same. We had the best 100% immunisation, and antenatal ways going. (Community member, Oct 23)

The Ngua Gundi program was identified in past research (Best, 2011; Dorman, 1997; Fredericks, 2009; Kildea & Van Wagner, 2012). The Rockhampton Children and Family Centre's 'Yadhira Gandanu Nulla' - Learning on Country Playgroup was considered a special and valued program by participants. Other aspects of ACCHS included health priority themes from children's to Elders health such as champions within health services, provision of counselling services, children's health programs such as Deadly Ears, health and social support services for Elders and ageing across the lifespan; National Disability Insurance Scheme (NDIS) support services as well as rehabilitation services for Alcohol and other Drug (AOD) use. There was mention that in the past and in earlier times, caring for Mob was done by Mob – and this was an inherent cultural aspect of attending ACCHS.

We're trying some new things at CFC [Children and Family Centre], ..., if they're educating parents side of things 'cause it can be harder. But 'cause we do nature play, ... once a month where we take our families out onto Country, ... to do playgroup. And the difference that we see, our Aboriginal and Torres Strait Islander families when they're out on Country connected with their children, they are open, they take more stuff in. It is absolutely amazing. Like just the difference. So, we've just received new funding and we're actually taking them out on Country twice a week now. And obviously then we'll be bringing support services in out on Country to support them and educate them because the difference we're seeing in them, and for those who have been to [the] centre, it's very natural, very nice. But they're so different from there to there. And just by changing the environment, we are seeing better outcomes. (Community member, Oct 23)

The sense of belonging to an ACCHS seemed to connect and empower community members. Building trusted relationships was seen as essential. The importance of belonging was significantly noted by staff who recalled a case of community women disengaging with mainstream health services due to their health workers moving on in the workforce. The significance of belonging, making connections and providing continuity of care is captured in the below quotation.

The old nurse unit manager, - - - She had left ... she was well known in the community as well. - - - she was non-Indigenous, but she was accepted by the community as somebody who cared for Indigenous women - - - who advocated for them, who would go out of her way to - and look after the Indigenous women here in town.

She was the person that they used to go to... but [name] worked hard to get them back on, get them back on. 'Cause [name] left as well for a little bit and we've been sort of

disconnected and waited for [name] to come back. Yeah, I'll come and see you again. So it was those familiar faces. (Community member, Oct 23)

Community champions are pivotal to the operations and ongoing continuity of care across healthcare services. Developing client-centred relationships was key to securing engagement, supported by wrap-around services that address the needs of Mum and her family, ensuring she did not 'fall through the cracks' of the healthcare system.

Yep. I think we need to – well, we need to – I think there needs to be champions in each... whether it's Bidgerdii, or whether it's another community led service. (Community member, Oct 23)

And then, yeah, a lot of our time is conversation, you know? Yes, we're – we're tinkering away doing our – our checking... triple heart rate. You know? Checking blood pressures and stuff. But it's just the chats - - - Then they know, you know, that they trust you. (Community member, Oct 23)

Aboriginal Community Controlled Health Services such as Bidgerdii CFC tend to have a low staff turnover, which has played a significant role in fostering ongoing client-centred care. This stability has helped build trust, continuity of care, holistic and culturally responsive care. A variety of services are offered at one location, including social-emotional support, educational and parenting programs, NDIS support as well as primary health check services. By centralising these services, it minimised the social and financial burden on families, including barriers to accessing culturally responsive healthcare, thus preventing less runaround and jumping through hoops.

CFC does not have a quick staff turnover, so they see the same people. (Community member, Oct 23)

... They know who you are. That's the key in this community they know who you are - - - It's a holistic approach from family support through to nutritional support, through to health support, through to, ... educational support, you know, parenting support. (Community member, Oct 23)

Developing relationships based on a personal level was key in building trustworthy relationships. Having prior experience or trauma-informed knowledge of the community's lived experiences facilitated by culturally responsive health workers engaged ongoing access to healthcare.

Yeah. But they're – like the stuff that here, Bidgerdii are doing, is absolutely wonderful. - - - Culturally competent, safe spaces - - They're doing all that. And then listening and giving you data. - - - That's all it takes to be with us Murri women and – and families. (Community member, Oct 23)

[We] got supported all the way through. Everyone was lovely. My brother boy, he has — he's been diagnosed with autism. These people here, they're — they're probably the best ones I — I've been through. (Community member, Oct 23)

But a lot of our staff too have been through a lot that they've been through so they can relate on a personal level with them and have those conversations. (Community member, Oct 23)

It was noted that numerous support programs were available for Mums, however, support programs for single Dads were limited. Dads who accessed support services at Bidgerdii were connected to the CFC program and staff emphasised the importance of developing more programs to meet the diversity and holistic needs of Dads.

We have a lot of single dads coming through our program just pushing their kids through, ... because they separated from mum - - - we try engaging with CFC and things like that. But there are very, very few support programs for dads. (Community member, Oct 23)

Bidgerdii is highly regarded within the Rockhampton community, with community members, including various health services praising the Aboriginal community-controlled health services staff and their ongoing commitment to culturally responsive care. The noticeable difference between providing services in culturally responsive spaces rather than clinical spaces draws attention to how culturally responsive environments facilitate better health outcomes.

And I agree with that. Like I'm a [work position], but I have, with health equity, I've been through part of implementation consultation with our communities, and I was privileged to go to an [event] recently and the mums and the children and the... interaction with the mums and they're all looking after each other's kids.

A mother walked there with five kids, I know, they cooked for each other and talk about – it was just – it's different to be- - - it was – it was [outdoor location], and it was just – I know, it was gorgeous, and they all just looked after each other's kids, but yeah. Yeah, you just have people who like being outside - - - Yeah, it's just amazing to be there. (Community member, Oct 23)

Due to its popularity, the increased intake at Bidgerdii has helped reduce long waitlists at mainstream healthcare services. However, with the growing demand for Bidgerdii's services highlights the need to expand programs not only within the Rockhampton community but also to surrounding areas such as Emerald and Blackwater where there is limited access to multifaceted culturally responsive healthcare.

I – I actually find it quite offensive, ... that Indigenous women struggle to get access to health. I find I've struggled with that for many reasons because I think that transport, like there's housing out at Blackwater but there's no public transport... to get them into health and to – and to [get them] access ... to health. This is a hospital here but it's... it's a non-birthing. - - Iron infusions. They don't do iron infusions out there; they need doctors and – but they don't do doctors. And if they need scans, they've got to come. Like, so they're just that access to health is an ongoing challenge for these women, and I really struggle that, like, why we're disadvantaged if I don't have a licence, if I don't have a vehicle of – of my [own]– you know, I just really – that pains my heart, actually. (Community member, Oct 23)

Certain Elders recommended that the theme of Holistic Health needed to be considered as 'Women's Holistic Health' and include antenatal and post-natal care, young mums' wrap-around pregnancy care and support, and sexual and reproductive health. Also, Elders mentioned the importance of culturally responsive health service delivery by Indigenous health professionals.

- Q:** *So then, thinking about what, priority you want to come down to one, ... are there concerns in antenatal...?*
- P1:** *I don't think so at moment.*
- Q:** *... Perinatal, postnatal, mental health?*
- P2:** *There's so many, hey. You can just rattle it off, hey? It's hard to choose.*
- P1:** *What about you look at what's available, instead of trying to double-up on it, expand out? Mmm... We have Indigenous people working in mental health, antenatal, child health. We've got them everywhere now. They're even doctors today, some of them... And ... diabetes... Sexual health.*
- P2:** *[But] we don't – we don't see them anymore in the community.*
- P1:** *No.*
- P2:** *We won't go there [to the health service] ... No. Well, we'll go around it, over it, or past it. But we know.*
- P1:** *Yep. They all – and in them days they did a lot of good work. I sit back and observe. Mmm... They did a lot of good work. (Community member, Oct 23)*

3.4.1.2 Health education - parenting education & programs

Access to health education in schools was mentioned as an important and meaningful approach to help shape children and young people for a healthy life. Health education served as a gateway to increasing health literacy among young people, to provide them with knowledge and skills needed to support them in their potential future roles as parents. Increased awareness of health education programs, ranging from physical activity and nutrition, sexual health, and perinatal education, such as breastfeeding support, were highly regarded by all service providers.

I don't know in terms of education wise, I – I'm a nurse educator myself, but I – I like to think that we're not just educating parents, we're actually working with them that way. And I – I think everyone here would really have thoughts in that, that sometimes putting those sorts of words at we've educated you, we've done this or we've done that, ... like it can actually create a barrier almost that, you know, we're really wanting to work with them, support them, assist them to do the best that they can for their kids. I know – and the majority of parents do want to do the best that they can. (Community member, Oct 23)

- P3:** *That's like with my little, ... great niece. She broke her leg, and now it – she's got like a little limp. And I was like, oh, you – maybe you should have did a follow up with the physio, so he can, like, assess her and so she's not – not – she won't have the limp, you know, for the rest of her life. And she's like, "No, the doctor said that's fine. It'll be normal."*
- P4:** *And they just take that onboard and just go away, like, you know, they – they don't question. And they don't know the difference, yeah.*
- P3:** *Yeah... And it's like maybe you should just – – –*
- P4:** *And then they don't go back and use like the service, like, you know – you know, like... because they don't know, like, they don't know how to follow it up on those sorts of things. (Community member, Oct 23)*

It was acknowledged that Dads at times felt isolated and had limited access to parents' groups, which could lead to feeling disempowered in family structures. There were very few existing support services or programs for single fathers, which was noted as a barrier to applicable parenting education and support. An example of such a program was the "New Endings Men's Health" program, which was designed to address these community needs. However, it was reported the program may not have been consistently accessed by those who would greatly benefit from it.

Well, especially with young people out in – our young people out in the community, what's happening with them, especially young families, you know, young mums. Or even the dads. Can't leave the dads out. Yep. Because there's a lot of good dads out there too. (Community member, Oct 23)

Community members felt health literacy was important to promote and maintain informed health-related decisions. Overall digital technology and social media were considered distractions for both parents and young children, at times affecting the physical and social activities which could be otherwise pursued. Some grandparents mentioned they provided kinship care which ensured medical appointments were prioritised.

P1: You know, they [parents] can't say transport, because Bidgerdii here provide all the transport, ... So there's no excuse in my book, you know. So what... what is their excuse with them not – not being - taking that child? I bet if they were sick they'd make sure they'd go see the doctors, and it might just be alcohol related. But a child – he doesn't understand – her or she doesn't understand what's happening with their little mind, body, what's happening, screaming out for help. And some parents – so I'm being honest – they don't want to take their child.

P2: It might be the grandparents come along and see it all. Like we all, you know - - -

P4: Like we do.

P1: Yeah. We're stepping in as grandparents. Because mums and dads just couldn't take that step. And they want to cry then, my poor baby. Mmm. So, yeah, because I've seen it, and ... it's still around.

P2: Yeah. There are some lackadaisical families. (Community member, Oct 23)

We got to educate our community, so invite Elders, community people, all the stakeholders that work with young people to come and listen to the people, experts in all these different fields. And that's been very successful. So they're the kind of things we got to look out of the box. If you look pure as only clinician, you only focus on the illness. You got to look at the whole... (Community member, Oct 23)

The abovementioned Learning on Country Playgroup offered by Rockhampton CFC, identified as a protective factor, was commended for its support and inclusion of both parents, and its successful engagement with community members.

So I – I think we need to look at, and we've been ... like advocating for a lot of families and stuff at the moment, going into meetings with families, with services and we just see them shut down when they're in spaces, clinical spaces, like, and they're just being talked to rather than, and that's why our families are saying to us, you know, they're not listening to us. We don't feel as though they want us there because they just, you can literally just see them shut down and – but when they're out on Country, they're just more open and they talk about things

more and it's just – so we're providing exactly the same thing. We've just changed the environment, and we are seeing huge differences in what our families are willing to take on. (Community member, October 23)

However, funding cuts to programs that worked was a substantial concern, which included the limited support programs for Elders and carers, SEWB and for youth.

Yeah. Because ... you know, the next I – I look at the future and where we're going to be 20 – 50 years. Us ladies around this table won't be here. But we're going to pass it on to our grandkids, hey. The next generation. The young ones. Yeah. And if there's something in place for them, I'll be singing in the heavens and watching how they're going. (Community member, Oct 23)

Parenting programs were recognised as essential tools in improving health literacy to empower and support young parents, and especially young single mothers. Correspondingly, there was acknowledgment of the generational matriarchs who are single mums themselves, 'surviving and thriving', and inherently living and demonstrating self-determination.

I think with the variety of services that we offer, so it's not like Bidgerdii, yes, health, but then we do the holistic approach. So, it's not just focusing on one area. It's a holistic approach from family support through to nutritional support, through to health support, through to ..., educational support, you know, parenting support. So, I think the whole – any service with a holistic approach, not just – because we have what? Seven Indigenous organisations within community, but we're probably the only one that does between Bidgerdii and CFC that does the holistic approach. (Community member, Oct 23)

3.4.2 Combined priority themes for Central Queensland Hospital and Health Service and Rockhampton Children and Family Centre (Bidgerdii)

The following themes were only identified as priorities for Central QLD Hospital and Health and the Rockhampton Children and Family Centre (Bidgerdii).

Strong Culture for Health; Barriers to health services access; Family & Domestic Violence - systemic neglect

3.4.2.1 Strong Culture for Health

Having a strong culture was considered a protective factor for health, and contributed to community feeling safe, strong and empowered. Having a Strong Culture for Health included the importance of upholding cultural beliefs, cultural obligations, traditional healing and medicine, language, practices and activities, programs and events. Similarly, spirituality and connection were important enablers for fostering better health outcomes. It is defined in teachings from Elders about Country, as expressed so poignantly by Dennis and Keedle (2019) –

“We are this country”, country is us, we are country. We breathe country, we drink country, we eat country, we live country. Country is everything, without country there is not life. So we sing country, we dance country, we care for country, we re-energise country. In so doing, through giving “thanks” we also re-energise ourselves and everything in existence. Birthing As Country is birthing with this deep knowing, with the knowing that we are country, country is us. I am not “on” the country, I am perhaps in country or with country but more deeply I am Country and Country is me and my baby”. (p. 384)

Connections included family gatherings, men's and women's business, teaching culture to the new generations, and consciously preventing loss or disconnection from culture. A strong culture of health was frequently practised in community. The sharing of storytelling and bush medicine were common elements, which connected people, place and Country. The significance of storytelling grounded one's cultural identity, building confidence and connections to people, affirming and empowering capacity to operate within the systems in the world around them. Forming ongoing relationships that sustained holistic connections to physical, social, emotional and spiritual health.

“Hey, guess what?” - - - She's always telling me where the crocodiles are, Country. I'm like, “You do not.” She goes, “I do so.” I'm like – so yeah. It's all about the bubbles and the currents [laughter] and, you know, like when women share [laughter] that cultural knowledge, as an Indigenous person in my own country, that storytelling sharing is like wow, you know? - - - just when people start to share their selves- - - how cool is that? (Community member, Oct 23)

Access to holistic ways of health and healing were found in cultural practices. Bush medicine such as Gumbi Gumbi was frequently used as holistic medicinal remedies for healing and health practices. It was readily sourced from community who knew the product and where to find it personally when on Country. Bush medicine was openly shared amongst family and friends. The practice of smoking was used as a healing remedy to ward off/cleanse unwanted illness. This practice has multifaceted purposes to cleanse physically and spiritually. Grounding was often used as a way of reconnecting with Country, identifying connection to people and place, which was at times practised in programs, as ways to reconnect and access holistic ways of healing.

I'm trying to say gumbi-gumbi, you know, how much gumbi-gumbi out there, can you pick me out some stuff. You know, that's the only way we get it. It's for healing. That's when - when I go back to my Country, going to Blackwater, Woorabinda, all that area. (Community member, Oct 23)

Yeah. No, I – I – what I do, I put it – get the girls to put it in the middle, and I invite people to walk through it. (Community member, Oct 23)

Go back to grounding on Country and things like that, or is that bush medicine, bush tucker, just learning about those things. (Community member, Oct 23)

Cultural workshops continued the teachings of traditional practices. The art of weaving and the knowledge of bush tucker are passed on in community groups and programs, engaging younger generations and reengaging families. Generational community members ran cultural workshops keeping the significance of cultural ways prominent.

So – so I go back out, up next ...I've got a – a ...a cultural workshop...So I go back there whenever I can. So [name], she works with the [program] and introducing these programs in Blackwater. and lately I've been talking to, ... a Gladstone mob, they run that Tucker Time. It's a Deadly Program.

[The] smoking tree, is – that – we, ah, they call it sandalwood, you know. We have it growing on Country. We don't have to go anywhere else to look for it.

There's a gumbi-gumbi organisation here in Rocky, they've got the gumbi-gumbi tree growing there, in their backyards...

They have... a lot of Rocky people have some traditional shampoos and ... tea leaves, and soap. Yeah. Well, in Blackwater, only last week, we started making soap out of gumbi-gumbi, sandalwood, lemon myrtle, and you name it... and we'd introduce that into the [school] classes. (Community member, Oct 23)

However, it was also noted at times a certain vulnerability among younger generations to connect with culture and engage in cultural ways as a strength. The breakdown of some family structures and the pervasive systemic racism within health care services, had the capacity to affect families in different ways and possibly hinder connection to culture and to cultural identity.

... Because I think they're children, they're young people, not children, pardon me. Adolescents and young adults, they've got to find a path and they will. If they feel that we're there to support them, they will - - - And also like the family system, family structures of – are no longer what they used to be. Where we'd have nan and pop in the house and auntie and uncle and you know, all the family and all the mob around. Like we're more isolated. I think our families are more isolated in this ... era. (Community member, Oct 23)

Societal burdens, including instances of systemic racism were identified as barriers that could limit a strong culture for health, especially for men and young people. The feeling of being removed from culture, disempowered and the possible difficulty of embedding culture within family structures could result in a negative impact and less engagement with health services.

I think society's taking that away - - - you're taking yourself away from the family. That's society - - - I believe some of that has disempowered men, but it also has disempowered other men because of what's happening to a small minority. (Community member, Oct 23)

Elders recognised that the passing on and practising of culture remained a significant factor to building a strong culture for health. It was identified that community members who pass on and consistently share language with their children and grandchildren are largely contributing to the positive affirmation of culture as identity and strength.

I – I – I look at the future and where we're going to be 20 – 50 years. Us ladies around this table won't be here. But we're going to pass it on to our grandkids, hey. The next generation. Yeah, yeah. The young ones. Yeah. And if there's something in place for them, I'll be singing in the heavens and watching how they're going. (Community member, Oct 23)

So they're constantly keeping her language... my wife's language, ... alive in there because they're – that's their DNA as well, that's their heritage as well. (Community member, Oct 23)

3.4.2.2 Barriers to health services access

Barriers to access included a wide range of concerns including access to health care; to medications (due to shortages); and to telehealth. This was evident in discussions around limited availability of appointments, which included a myriad of reasons such as: referrals and waitlist times; financial pressures especially when needing to access specialist services; lack of bulk billing and affordability of services; limited support for health professionals; location (limited access to health services); shame in diagnosis; terminology or jargon – communication and comprehension difficulties and the ‘feeling of being talked down to’; culturally safe case management; environmental factors; funding services that stop at a certain age; health equity; limited access to health professionals, e.g. doctors, specialists, AHW’s, allied health; limited awareness of health services, e.g. services not being promoted; and limited follow up after appointments.

Some families are very good at accessing services. So, when you go to some families, they might have three or four sometimes up to six services involved. So, you've got all those services with this family, but this family over here is on a waiting list. Like I just, I – I don't understand sometimes the duplication of services and – and it's just like, you know, if we moved those five to these five families that's now six families, we've addressed instead of this one having six services. (Community member, Oct 23)

The main barrier to community healthcare needs identified by health workers was the limited access to birthing hospitals when residing in remote locations, as well as the financial and time burden of travelling to regional centres. Birthing in remote areas of Central Queensland proved a disadvantage as only non-birthing hospitals were operational, with limited resources for mothers to birth on their own Country. The lack of public transport to and from remote locations also made it challenging for community members to access healthcare. Some community members travelled over an hour to access appointments whereas other community members did not have transport to travel long or short distances.

Whereas ours travel from most of Aboriginal towns around is an hour away. (Community member, Oct 23)

Referrals for complex health needs were challenging in remote locations with long waitlists and limited access to specialists' support.

It's struggling with – with meeting the community needs already. - - - we do a one day a week midwifery service out there, and it's chockers - - - you're left to refer these women back to their GP, which – you know? They may not get into for a couple of months. (Community member, Oct 23)

Staffing shortages also contributed to delays in accessing specialist healthcare needs, with at times community members missing out on seeing a specialist unless they had acute healthcare needs. Nevertheless, it is important to acknowledge that healthcare staff often prioritised care by employing creative strategies to minimise delays. Additionally, the underrepresentation of Indigenous health workers limited the provision of culturally responsive care and therefore community engagement with health care systems.

They're – they're so short staffed - - - not specialists in perinatal mental health - - - We get the ultrasounds like I've just now - - - favours with ultrasounds. You feel like sometimes you try and try and try but there's – there's always red tape. (Community member, Oct 23)

Maybe we need start risk managing this stuff - - - If we're not actually recording it in these systems that help us record and understand incidents and where things are breaking down - - it is a health equity issue now and that is the biggest thing. One of the strategic priorities of this essential... (Community member, Oct 23)

Relocating for healthcare placed a significant financial and social burden on families, including access to accommodation, food and transportation.

To get them into health and to – and to access them to health. This is a hospital here but it's ... It's – it's a non-birthing. (Community member, Oct 23)

Putting her over to the Red Cross room is all very good, but then we've got to get – she's got to pay for food and like there then becomes away from family. And then I've got to provide food, and what does that look like? (Community member, Oct 23)

So I'm starting to just tackle those bigger issues about trying to keep mums and babies together, and - - - I feel challenged that there's no support services. - - - She sent me this beautiful message and said, "Thanks, I really appreciate all that you've done." You know what? That's worth more than my paycheque. (Community member, Oct 23)

Medical terminology, often referred to in community as jargon, at times disadvantaged community members' awareness of medical conditions, diagnosis, treatment and medication concerns. It was shared that there was uncertainty around what to discuss, which questions to ask, how to request a second opinion, and feelings of shame were common. These challenges further deterred healthcare engagement.

Well, it's not just young people. Like, right across the, ... like, you know, go to one of those, just take onboard what – because they're the expert, like, you know. - - - they get medication, and they'll just go and take it. Like they don't realise what they're getting it for. (Community member, Oct 23)

Furthermore, contributing factors that presented as a barrier, especially for men to access healthcare was shame. For many cultural men, disclosing men's business to female health staff was inappropriate following cultural protocols. Health care systems were not always equipped to provide culturally responsive care, including for men's and women's health business. This inevitably caused barriers to accessing health care.

... But they find that going to doctors, um, at that specific time and there's women there and they know women there with their issue and being ashamed about going up to the counter and saying, I'm here for something, ... whatever the main issues are... There's that type of thing that holds men back. (Community member, Oct 23)

3.4.2.3 Family and Domestic Violence – systemic neglect

Family and domestic violence (FDV) was reported as an ongoing issue for some families and was characterised by continuous neglect of an individual or systemic neglect. The latter refers to the

structural disadvantages created by government policies in eschewing their responsibilities to provide support and resources to families most in need (National Justice Project, 2025). This was often associated with ongoing life stressors, such as alcohol abuse, unemployment and criminal history. It was noted that some individuals had repeat encounters with crime and jail time, which then negatively impacted on their employment opportunities. These systemic failures often placed cyclical financial burdens on individuals and families.

You drink a bit of, ... strength there to do whatever you gotta do, then you end up in prison. Once you end up in prison, you know, if you are making it a regular then comes... the criminal history against you and employment. - - - Can't provide for the family because you've got no job, uh, no money. Unhealthy eating, domestic violence, and everything else that, you know, comes with that. (Community member, Oct 23)

Staff acknowledged that FDV is a difficult subject to address and support which affects health and wellbeing for all involved. Rockhampton was noted to be the fourth highest city in Queensland impacted by family domestic violence.

And this is with, like with the health service that has a zero-suicide initiative, and we have domestic violence policies and things for our staff as well. It's not just anyone, is it? So there's staff and a bit of those other things. So yeah, they're definitely hard subjects but obviously you know, like they affect health and everybody. (Community member, Oct 23)

Accessing FDV services was challenging for many. Programs were available to support FDV, however, health service staff identified that the community may feel a lack of safety talking outside safe spaces, and some FDV concerns were regarded as family business. Acknowledging this was not meant to devalue the need for services or community choices, rather it recognised the barriers that community face and the associations that affect community health.

Yeah. I just don't think they feel safe talking about outside of the circle. I think they think it's this family business, and it's really difficult to link them. You can provide them with information that's really, really difficult. (Community member, Oct 23)

3.4.3 Combined priority themes for Central Queensland Hospital and Health Service and Bidjerdii Elders Groups

The following themes were priority areas for Central QLD Health and Bidjerdii Elders however, they were not identified as a main priority area for Rockhampton Children and Family Centre (Bidjerdii).

Diagnosis Requiring Early Intervention; Chronic Disease; Youth Support & Programs

3.4.3.1 Diagnosis requiring early intervention

Early intervention was recognised as facilitating allied health services to support and meet the needs of children's developmental milestones in a timely manner. Extensive waitlists existed for diagnoses related to concerns such as speech development, Foetal Alcohol Spectrum Disorder (FASD) and

autism spectrum disorder. Health service staff noted that long waitlists became barriers to accessing support to meet community needs.

Aside from hearing, speech, speech is a big – there's a gap there with speech and then prepping kids coming into school. (Community member, Oct 23)

I'm just thinking off the top of my head, um, what families that might have young children that haven't yet been diagnosed with whether they've got autism, or, um, ADHD, or things like that. I don't think there's enough, um, services around to speak to our Murri families about that. (Community member, Oct 23)

Community members felt that some health care services were at times dismissive of their needs and that their concerns were not taken seriously, which deterred families from continuing their engagement with health care services. The lack of services to manage the influx of early interventions was of great concern for service delivery across all age groups.

I think Rocky's sitting about 8.2% Indigenous within the community where Queensland I think is around 4.2 and Australia's about three point something. So, we've got a really high number of Indigenous populations in the Rockhampton community, but with limited resources, culturally appropriate resources. (Community member, Oct 23)

Health education and promotion of health checks, and identification of attention deficit hyperactivity disorder (ADHD) and autism, were considered important to raise awareness of what emulated strong health and how to maintain strong health.

That is just the nature of adolescents- - - and it's really reinforcing those healthy habits and healthy behaviours. We got to educate our community, so invite Elders, community people, all the stakeholders that work with young people to come and listen to the people, experts in all these different fields. And that's been very successful.

... And our adolescents. And they're go into adulthood being labelled as problem kids when in fact they've got [a] brain injury. And I'm thinking it's preventable. And how we work towards that and education, education, education. We have to educate, and it is everybody's responsibility to educate. (Community member, Oct 23)

Recommendations were made for a 'one stop shop' such as the ACCHS' model of holistic care to diagnose and assist in managing neurodevelopment challenges, including autism, cerebral palsy and other developmental delays, which would also help to minimise extensive waitlists. Inclusion of allied health in the early intervention stages was important, for example, speech pathologists and physiotherapists. Continual barriers to referrals for developmentally vulnerable community members were also mentioned.

P1: Well, early intervention... I know they do a lot of stuff with babies not being born [yet], in utero. So, they know by the screening of the scans, or whatever happens, they can go in, open mum up and do the surgery now these days, medical intervention is top of the carts [sp], you know.

So, well, I don't know. I'm just throwing one of them, is around the brain. I don't know.

P2: And going – when you go back to ADHD, a lot of our mothers, the kids have got foetal alcohol syndrome. I've seen treatment - - -

P1: *That's connected. See how they're connected.*

P2: *--- done for ADHD, because they can get a payment from Centrelink. But we can't diagnose FAS [Fetal Alcohol Spectrum/Disorder], unless they're qualified them to diagnose them as a FAS... Diagnose.*

P1: *Like we had no-one – we can know the science and symptoms, but they've got to be diagnosed. (Community member, Oct 23)*

And look, you work with youth justice. So, on the source — source, which is serious repeat offender. And [the] cohort, they're a 85, 95% are Indigenous. So sad. And they're on the verge of going into custody, so I'm the health representative on that to make sure, and I very much look at and make sure, "Hey, I think there's FASD going on here, let's get them diagnosed." "I think this might be an issue, let's get linked into here." So, bringing the health aspect to consider other things rather than just thinking about the other things. So, bring them the health aspect.

That education and those things. And gradually working towards having actually a FASD clinic such as --- So that's what we're working towards. (Community member, Oct 23)

3.4.3.2 Chronic Disease

The burden of chronic diseases was a persistent concern among community members. Conditions commonly reported included, but were not limited to, Rheumatic Heart Disease (RHD) and related skin conditions (eczema), Diabetes, Heart and Kidney disease and Asthma.

There's certain skin issues, which then creates the issues around rheumatic heart disease, which we have an issue with... we're finding that the skin stuff and infection stuff is actually then having long-term health impacts. But the sooner we work with our babies and our mums and our families and stuff, we're going to, you know, slow down the impacts of some of this stuff if we get it right here. (Community member, Oct 23)

These programs are developed for our young people to vulnerable young people to succeed. So, we go and do talks with them and they're obviously a little older. They can be also, ... you know, 20, 19. And they ask me if I can explain it or they come and see me one-on-one, and I'll do a whole health assessment and then determine where are the health needs... mental health do you need counselling and have the... chronic health condition. And you know, if diabetes, is it managed very well and teaching those things and try and refer them back to other services. (Community member, Oct 23)

Q: So is diabetes a – a big, ... health concern in Mount Morgan?

P3: *It's a big thing here. Mmm.*

P2: *Yeah. Big – yeah, because half – half – half our bloody mob is all – got diabetes of some sort. (Community member, Oct 23)*

The need to manage medications adequately required consistent communication between health care services and further health education opportunities with GPs, ensuring community members gave informed consent.

P1: I'm happy with what I've got, that I'm using at the moment to control my diabetes. My diabetes is good, but he [doctor] wants to play around with them again.

The thing is... yeah, they changed the medication, it works. It's going great. A couple of months of doing it, and it's really getting good. Then they stopped the bloody scripts going to the chemist, and you can't fricking bloody get it, because every other bastard wants to lose weight, and we can't get – you can't get it, when it works really well with your insulin, and it together are bloody perfect, everything is going nice, and then all of a sudden, you can't get it for two or three months.

P2: Yeah. No, nothing, yeah.

P1: I haven't had it for two months, and my – my readings have gone back to shit again. I was getting perfect readings for two months, oh, three months actually – three months I was on perfect readings. But the month after I'd seen him, couldn't get the bloody stuff, and haven't had it since, and now my readings are back up in 18 to 19s. (Community member, Oct 23)

3.4.3.3 Youth Support & Programs

Both mainstream and community-controlled health service staff recognised the importance of providing support and program services for youth. Whilst some of these programs and services existed in schools and community settings, the limited availability of youth services and programs remained a key focus for funding and to ensure adequate access to these for young people.

See, we used to go into schools with our little program, do Foetal Alcohol Syndrome (FAS) with our high school kids. But we didn't have the funding – anymore money to keep going. (Community member, Oct 23)

Doctor is always saying the kids need to go to see psychologists, whatever. You can't get into anyone. No-one is taking any more patients. There's not enough to go around. (Community member, Oct 23)

Furthermore, accessibility of early intervention and diagnosis for young people was also reported as a priority. It should be noted that community acknowledged young people generally were not causing trouble for no reason. Perhaps, on reflection, early intervention and diagnostic care would have enabled young people to receive the support they need during early developmental stages.

I work with our 14 to 25-year-old[s] and, ... Indigenous young people across Central Queensland. And — ... so because focus on — focus on the vulnerable young people, so therefore it brings up a lot more young people who are tied up with this child safety system...

I feel like this program was — we've created this program ah, through [government] funding ... to address STI [sexually transmitted infections] in Central Queensland. And when I looked further into, I really was concerned about teen pregnancy here in Central Queensland and that's why I added that as sexual health and reproductive health.

So as the schools were building up, these alternative schools, ... are very quickly identified that there was, ah, no service going in there and they — they were highest risk young people. One of the schools was 70% Indigenous, the other school at Woorabinda is almost 50 — 90% — sorry, almost a hundred percent Indigenous.

We are really trying to bring them back to thinking about their belonging as well and reinforcing that. Reinforcing and bringing them their own inner worth. So that's why [the programs have] names like Care, Connect, Inspire, Protect, Empower and Respect. (Community member, Oct 23)

3.4.4 Combined priority themes for Rockhampton CFC and Bidjerdii Elders Groups

Both the Elders groups and the Rockhampton Child Family Centre of Bidjerdii agreed that the theme that incorporated Mental Health, Social & Emotional Wellbeing and Grief & Loss was a priority.

Mental Health, Social & Emotional Wellbeing and Grief & Loss

3.4.4.1 Mental Health, Social & Emotional Wellbeing and Grief & Loss

Mental health spanned across various conditions including anxiety, trauma, youth mental health, grief and loss, Sorry Business and suicide. Of the mental health support programs or services that were on offer, only some were deemed effective by participants. At times, the stigma and shame became a barrier for individuals to access social emotional support, which resulted in suppressing their own wellbeing concerns. Waitlists for social and emotional wellbeing programs were long and became too difficult to access.

That's the stuff that mental health comes... because I worked with domestic violence and ..., everybody was going off the nut because of the way they, their thinking. But if you are unhealthy thinking and you're unhealthy, you can't get – two wrongs don't make a right. You can't come with good sense, you know I'm saying like that. Or make good decisions until you, you know, get support. And that's the other thing, us Black fellas, either we are proud or stupid, but we don't get support when it's all out there. Nobody should be walking around the way we are because too many of our Elders have fought for organisations, you know, and took all the black this black that. But then community doesn't want to use that organisation yet. Our forefathers and foremothers fought for it; you know? And ... yeah, that's, so we sit in our little circle and don't get the support and ... we stay stupid, or we stay unsupported, stupid is a harsh word but unsupported because then you – you teach your children that and your children's children. (Community member, Oct 23)

Overall, social and emotional wellbeing was a key priority which was highlighted by Elders' groups, and they made sure the research team captured their thoughts about what the community needed to be addressed to make a real difference. Elders particularly highlighted their passion for change in their communities.

P1: We need one – one focus on one health outcome. If we get one healthy health outcome, and from what you – researchers are doing, that'll be a step forward for us... don't keep talking to me about closing the gap. Because I'm sick of hearing that shit. And... that's – that's gone. That's under the carpet for me. Well, that's only personally for me, ladies, so.

P2: Yeah. Everyone is different, hey [name] you know.

P1: Yeah. Yeah. But they're – like the stuff that here, Bidgerdii are doing, is absolutely wonderful. They're doing all that. And then listening and giving you data. That's all it takes to be with us Murri women and – and families.

Q: And that's the approaches, hey? Being culturally competent, culturally safe places, yeah, all those approaches.

P1: Yes. And don't go taking that information and changing it to suit you what you – and what your – and what timeframes, timelines, you need to meet. You need to keep coming. And that's what you're going to have to do. You're going keep going back to those communities and ticking the boxes and making sure those people are - - - are the – their needs are getting addressed. That's me. I'm shutting up now, ladies.

P2: No [laughter].

P3: No, no. You keep going.

P1: When you start talking about health I get - - - Very emotional about it, by the sound of it.

Q: But see, that's what we wanted though. We wanted truth, you know. We're here for truth telling. You know, stick it to us, if you need to stick it to us, because that's what part of the recording is too, because then we take that back.

P1: Mmm. Yep.

Q: We'll transcribe it. And we'll stick it to the next person. But we'll also follow it through, and it – that's all about being community led.

A: Yeah.

Q: That's what we're, yeah.

A: Yeah. Because, ... you know, the next – I – I – I look at the future and where we're going to be 20 – 50 years. Us ladies around this table won't be here. But we're going to pass it on to our grandkids, hey. The next generation.

P2: Yeah, yeah. The young ones.

P1: Yeah. And if there's something in place for them, I'll be singing in the heavens and watching how they're going. (Community member, Oct 23)

Respondents from the CFC mentioned how valuable the service and staff were for community members in need of extra support, with social and emotional wellbeing wrap around and holistic care reaching those most in need.

P2: Yeah. See a lot of good times there. The – yeah, what they can, to help anyone who walked through that door needed help. Even going to riverbank.

P3: I was there for the ones who lived on the riverbank, and all the ones who drank.

P2: Yeah. And they [Bidgerdii] still do today, you know, like, help them out. Yeah. It's just amazing. It's amazing. (Community member, Oct 23)

Social and emotional wellbeing programs and services needed to include considerations around case management, addressing FDV and ensuring the provision of women's shelters. The focus had to be on empowering survivors rather than casting a continuum of shame. Enduring safety concerns had an emotional load on community, at both personal and community levels.

And it's – and I don't mean to be rude – disrespectful to anybody, or it's – we've been through this before. And I think some of us are feeling very flat and low. This is – this is how I'm feeling. So why come and ask me to come to something like this? ... I feel like I had to go out walkabout on country, because of here comes another research. And the frustration of another research. I – I love health. Health is my passion. Mothers and baby, children, FAS, drug and alcohol; I've done all that. But I'm just saying, what are we going to tap into for one that is going to be important for all of us, that are going to affect our children, grandchildren, and – and there's so many. (Community member, Oct 23)

P3: At the moment and for health wise, mental health is a big thing.

P4: Mental health in Rocky is no good.

P2: No good. (Community member, Oct 23)

You can go to the hospital, and we've got people here that have been to the hospital, and they've just sent them home because they have no beds for them... So, like that wanting support, but there literally is nothing here. And I think that's the same everywhere. (Community member, Oct 23)

Alcohol and other drug use were contributing to the ways in which individuals dealt with their own mental health issues and traumatic experiences, such as through self-medication.

I know a lot of people that I work with, I'd say the majority of them, you know, they – they've all got some – and that – that's another reason why a lot of them could probably turn to alcohol or drugs, is because of, you know, some sort of, ... what's the word I'm trying to use, - - - Trauma, yeah. - - - They do – I was speaking to ... one about one of my clients, and ..., he mentioned to me, ... because of all the – she hasn't sort of dealt with all the trauma that's – that's happened in her life. And ... that's why she sort of drinks... (Community & staff member, non-government agency, Oct 23)

... Substance use, the families' habits have to be — yeah because of their trauma, their experience was sent down from one generation to next. (Community member, Oct 23)

3.4.5 Priority theme for Rockhampton Children & Family Centre (Bidgerdii)

This theme was only highlighted by the participants of Rockhampton Child Family Centre (Bidgerdii).

Social determinants of health – access to transport support

3.4.5.1 Social determinants of health - Transport Support

Some of the health research priorities arising from considerations of the social determinants of health included education, employment, financial stress, limited housing, including overcrowding, food security, and mental health.

I think society's taking that away [from men] in the sense of drink, go to jail. So, you – you're taking yourself away from the family. That's society. ... some cultural beliefs, ... which said unemployment comes along and then it's like, well you're not a father because you can't provide, but you got no – you can't get a job [laughs] because you're big noting yourself there. And... so I believe some of that has disempowered men, but it also has disempowered other men because of what's happening to a small minority ... so that it – it looks like – it looks like that. (Community member, Oct 23)

Cost of living and financial stressors were a constant reality for many families with CFC participants. An ongoing lack of resources led to compounding health concerns for many in community.

... Skin conditions is one that we see regularly. And it usually starts with one then goes through the whole family... and that's not because they don't care, it's because they don't have the sheets to change them regularly or they don't have the resources to be able to do it. Where people are actually just – and, you know, we've heard conversations here, oh, you know, but they're not doing this, they're not doing that; well, they're not doing that because they don't have the resources to do it. Like it's just that they don't have the tools or the resources or the money to be able to purchase it. (Community member, Oct 23)

Transport support was a sub-theme prioritised by the Bidjerdii CFC, noting issues around travel to specialists and hospital appointments, isolation and having no family or no access to home support.

Like even we've had children go to specialist appointments, ... in Brisbane. Two days out, they've still had no communication about transport. (Community member, Oct 23)

So prime example, we've had, ... parents call us here because they've missed paediatrician appointments because they've had no communication from Queensland Health or they can't get there, but then it's too late. We cover transport just to get those families in that door to see them.

And that shouldn't be the case. They should have – their transport should be organised. But I know when I went to Aboriginal Health [location named], never had an issue. There's actually a transport and it's all there; people don't know because they're not out there mingling with... Back in the day, they used to ring you and go, "Hey, you've got an appointment coming up next month, will you need transport?" (Community member, Oct 23)

But one of the biggest issues, ... I see is probably, ... for people to get to these things. A lot – I mean, some people offer transport, others don't, so, you know - - - transport for some people can be very hard for them to participate. (Community member, Oct 23)

Staff and community members recognised that program funding directly affected clients who were able to access programs and services delivered in an ACCHS. This was also inconsistent with transport support that could be accessed through other health services.

Yeah, I think sometimes the mainstream organisations are what's best for them and what's easy for them to deliver the programs rather what's best for the client, because as we know, transport's a huge issue. (Community member, Oct 23)

Then patient travel doesn't – we – we don't, ... subsidise, ... appointments to dental, any dental appointments. So they've got to come to get teeth pulled out or whatever or get dental care. Patient travel won't support them. (Community member, Oct 23)

3.4.6 Priority theme for Central Queensland Hospital and Health Service

The theme Challenges Using Mainstream Health was identified by CQ Hospital and Health service as a priority.

Challenges Using Mainstream Health Services

3.4.6.1 Challenges using mainstream health services

There were robust discussions around this theme with CQ Health staff, which generated numerous sub-themes, including: the difficulty of navigating through a 'broken system' for community members and support systems for overloaded services and staff.

It's just sometimes about how do we help them navigate those systems? How do we put in place supports that, ... you know, can advocate for them, ... along those – along that pathway. And sometimes I see it that we don't sometimes understand the process ourselves enough to be able to assist them to step through because our systems keep changing. And so that's one of the issues that I think, ... you know, just helping them navigate. We – we have made some inroads with, with... physicians to be able to do that. Still, it's still – I think have a lot more work done. (Community member, Oct 23)

Staff recognised that not all communities have good access to health care professionals.

We've got people from Emerald taking their children to see a doctor in, ... Sheba to get a referral to an ENT. It's quicker to drive to Sheba than to wait for a doctor's appointment. So just access is huge – access is huge. (Community member, Oct 23)

Other issues included communication breakdown, for example missing discharge summaries, early discharge or dismissal of clients and lack of patient-centred care.

The other thing around antenatal care and even what happened here locally is there was changes into antenatal care, but that wasn't – that wasn't sent out to the community. So, I know as the child health nurse, basically they thought that Indigenous, ... antenatal care had ceased. They – they were saying that to me that there isn't any antenatal care, which just, it wasn't correct, but it hadn't been put out to them before it happened, or the changes were made. (Community member, Oct 23)

We did a focus group with our parents, ... middle of last year with PHN [Primary Health Network] and the biggest part, the biggest that come across is a lot of mainstream services, our families don't feel like they're wanted there either. So, and I think that comes down to the waiting, the referral process. The thing that come across very, very clear from our families is that we feel as though we're not wanted there, so... So, I think they're being dictated to a lot and not – because that's what they said. They said they don't feel as though that we're wanted there, and they don't listen to what we actually want. (Community member, Oct 23)

Inappropriate service delivery was stated as focusing on what was best for the system but not best for the needs of the patients. Health professionals and services staff recognised the need for ongoing culturally responsive training, noting that they had experienced the conditioning of coerced systematic practices.

The lactation nurse, lovely lady, but she was an older white lady as well... she's got very strong views, and you know, in my head I was thinking, oh, I wish I just, you know, had a auntie who I wasn't related to that I could speak openly and truthfully with and say this is what the problems are... they didn't have a [Aboriginal and Torres Strait Islander Hospital] liaison officer, but they were very – they knew who I could reach out to and gave you all the information from people who I could reach out to. But there was no, ... like Murri lactation nurse that I could go to, so... I ended up, ... having a – what – what made me sort of make my mind up about it was I ended up talking to my best friend's mum. She wasn't – she's not related... wasn't related to me, but I knew her through my best friend and she knew what was going on in my life and she's not a judgy person or anything, and I just broke down to her and she goes, "you know, you don't have to breastfeed" [laughter]. (Community member, Oct 23)

Further discussions related to this theme included the systematic investigation of living conditions; management decisions not reflecting community needs; the process around missed appointments; the need to 'manage their patients correctly'; lack of continuity of care with patients required to repeat their story time and time again; no at home support for elderly and limited staffing.

And that's where these women that are higher risk, have lower socioeconomic status, need more, should, I feel like that one-on-one sort of thing, continuity would benefit that. (Community member, Oct 23)

Working in MGP, you – you get snippets of the women that actually do get missed and that... fall through the cracks because they – they haven't got the continuity... they're seeing a different midwife each time, they're missing appointments and it's just getting rescheduled. Whereas if my lady misses an appointment, I'm ringing her going, "Hey, where are you? You missed your appointment. Let's reschedule for tomorrow. Do you need me to come and do a home visit, you know, can I see antenatally at home so that, ... if you've – if you haven't got your car or it's broken down." You know, ... the women that don't have that continuity can get missed and that's probably – and they do. (Community member, Oct 23)

They've got to tell their story every single time there's a new midwife, you get [sick of it] ... tell them the same story about yourself, yeah, so they just don't go. (Community member, Oct 23)

So yeah, that's probably a continuity and like for us, some of our support services that come in, we might get this person one day, this person another week where for me it'd be great if we could have the same person. (Community member, Oct 23)

Ultimately, the fact that mainstream health services were centred on Western ideals and medication treatment rather than on acknowledging a blend of holistic approaches to health emphasised a consistent barrier for community.

That cultural diagnosis [not the clinical, the cultural diagnosis turning into clinical and they try to medicate us with the white man's, you know the clinical stuff] but it's really a cultural matter, you know? It's a holistic approach from family support through to nutritional support, through to health support, through to, ... educational support, you know, parenting support.

But they're constantly then going and changing, having to tell their story again, having to access another service, having to go to another building, having to go – where I think if we had more services that did a holistic approach, you – we get – that'd be better outcome. (Community member, Oct 23)

4. Discussion

This study has undertaken a systematic approach to identifying health priorities driven by Indigenous communities and health professionals of Central Queensland. Many of the health professionals included as participants, also identified as community members themselves. Key health themes identified have the potential to guide adjustments to health service delivery, while others may facilitate future perinatal research or health program focus areas for the Rockhampton region. Study results also aimed to support the future of co-designed research programs.

Findings of this report for the Rockhampton region emphasised 10 key health themes that call for health services to prioritise culturally responsive practices as best practice approaches within their services. These themes provide valuable insights to help facilitate the need for equitable partnerships that foster shared decision-making. Centring the voices and needs of Aboriginal and Torres Strait Islander communities in the region provides valuable guidance on how they want to determine the health research priorities of their communities. Approximately 194 themes and sub-themes were identified during data coding and analysis. The combined themes amongst Bidjerdii Elders, the Rockhampton Children & Family Centre and Central Queensland Health groups included the importance of Aboriginal Community-Controlled Health Services (ACCHS) and holistic health, focusing on health across the lifespan. Similarly, health education and in particular, parenting education and programs were unanimously chosen as key themes by all three organisational groups. Barriers and access to healthcare services, specifically ongoing racism as a high contributor within health services and programs, and siloed services were specifically highlighted by the Bidjerdii Elders groups and Children and Family Centre.

Mental health and social-emotional wellbeing were significant factors due to the ongoing effects of trauma, grief and loss, which contributed to broader mental health concerns. Addressing the interconnectedness of mental health, grief and loss is essential to strengthening social-emotional wellbeing programs and access to support services for the Rockhampton community.

The study's findings highlight a correlation between alcohol and other drug use that exacerbated situations of family domestic violence. Alcohol was perceived as a catalyst that served as a coping mechanism for underlying trauma, grief and loss, and other life stressors. Findings also emphasised the need for culturally responsive programs and highlighted that, unless delivered holistically and with a focus on strengthening community wellbeing, such programs will fall short on meeting community aspirations.

Community highlighted the need for continuity of care and culturally responsive care as key themes to strengthen overall engagement with all healthcare services. Additionally, the community was invested in embedding cultural knowledge and practices to foster a strong culture for health. These findings emphasised the value of more Aboriginal and Torres Strait Islander health workers, encouraging services to address the limited representation in healthcare services.

Being strong in culture represented resilience, and connecting with Country embodied the benefits of holistic well-being. Connectedness with programs showed a strength in community engagement, being amongst like-minded people provided social support, empowering health education and treatment. Being connected to Community was a significant social support that grounded participants and was beneficial to wellbeing.

It is hoped this report contributes to the empowerment of Indigenous communities, through sharing their stories, and facilitating the processes of identifying community health research priorities. This body of work aimed to achieve authentic, culturally driven responses that determine the principles of co-design, reflective of a movement of culturally responsive design (Anderson et al. 2022).

Overall, the health themes identified in this report provide valuable guidance on how Indigenous voices of Rockhampton determine solutions to the health needs experienced in their communities.

5. Strengths and limitations

Participants in the yarning sessions expressed open and honest communication from community members and health professionals and provided an in-depth lens of health priorities that impact Aboriginal and Torres Strait Islander communities in the Rockhampton region. Community identified that breaking the cycles of alcohol and other drugs had the potential to change the effects of family domestic violence, mental health, chronic disease and social determinants of health, strengthened by early intervention programs and management.

Face-to-face yarning sessions with Aboriginal and Torres Strait Islander community members and health professionals were imperative to strengthen the findings of this study as the dual perspectives added richness to the data throughout. Opportunities to listen and learn from community members, providing rich and informed data that established ongoing partnerships setting the foundations for planning and delivery of future collaborations and opportunities throughout the study. Community champions at each site and health professionals were invaluable in the recruitment of study participants.

Despite the high level of engagement during Phase 1, there was limited engagement in Phase 2 with all services experiencing conflicting time commitments for undertaking Delphi workshops (Phase 2). A male facilitator led work with male specific groups to ensure cultural appropriateness of processes and discussions for men's business. However, like other regions where this study has been undertaken, a continued limitation was the lower participation of men from the community within the study. The inclusion of more male voices should be explored and established in future studies.

5.1 Future directions and recommendations

The strong and overlapping themes presented in this report can serve to guide research teams and executives to reflect on these findings and consider opportunities to collaborate across your region for future programs, services and research.

Recommendations to prioritise the development of support programs for dads, and especially for single dads and to provide support around men's health issues were further emphasised by the

managers during the feedback session. Furthermore, the provision of additional ACCHS clinics to service increased demand was an ongoing recommendation, however.

6. Conclusion

This study aimed to contribute to prioritising community ownership of research through the process of identifying health research priorities with, by and for communities using Participatory Action Research principles. This report could assist healthcare services, (ACCHS, government health departments and non-government organisations) in the Rockhampton region in planning future programs, services, and research. The study findings have identified health research themes as identified and prioritised by Aboriginal and Torres Strait Islanders from Bidjerdii and CQ Health services. These self-determined priorities focus on making a difference for young families across participating Queensland Indigenous communities at a time when it counts the most – the First 1000 days of life.

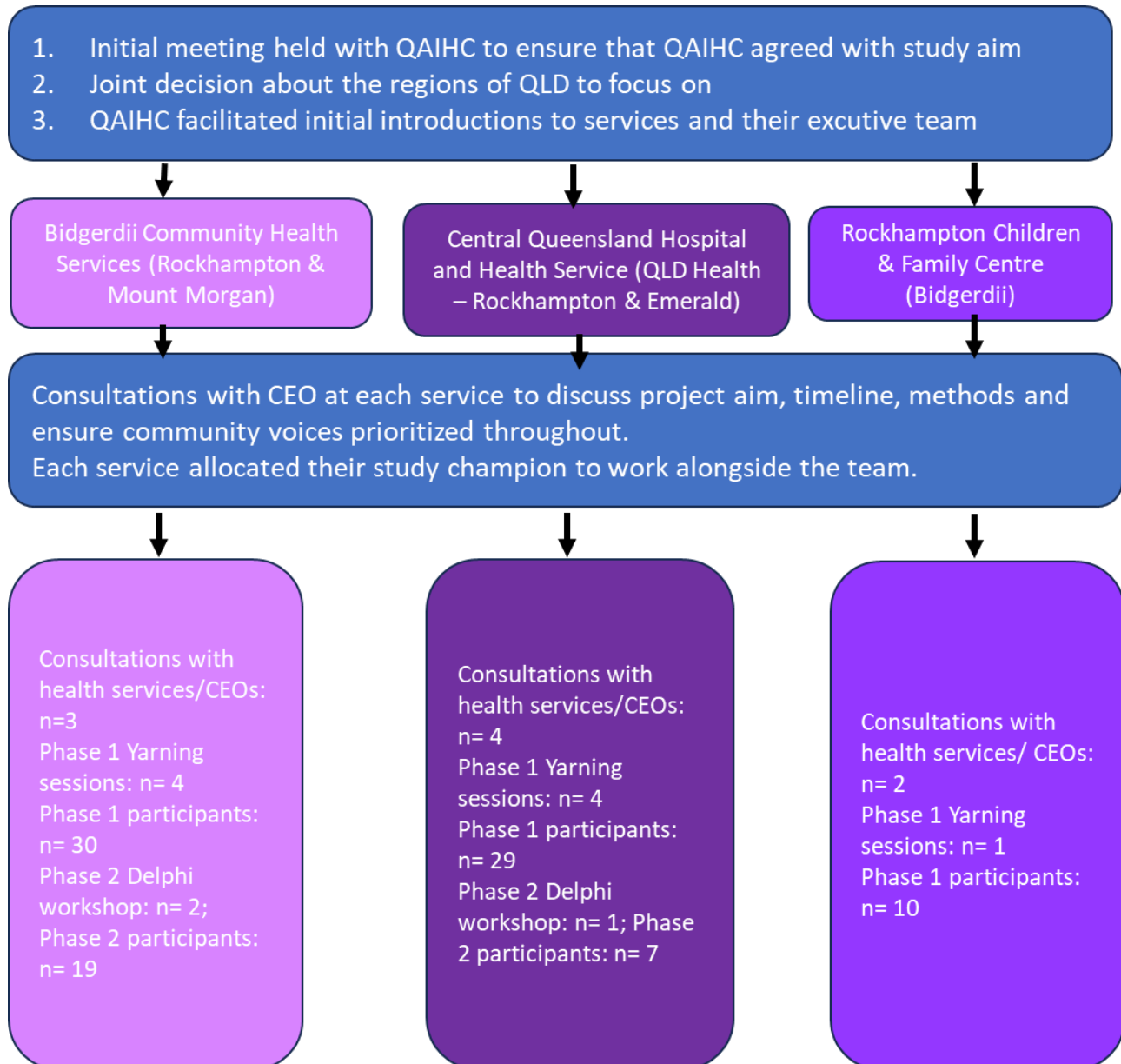
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8. Appendices

Appendix 1. Study site visits diagram



Appendix 2. Coding framework

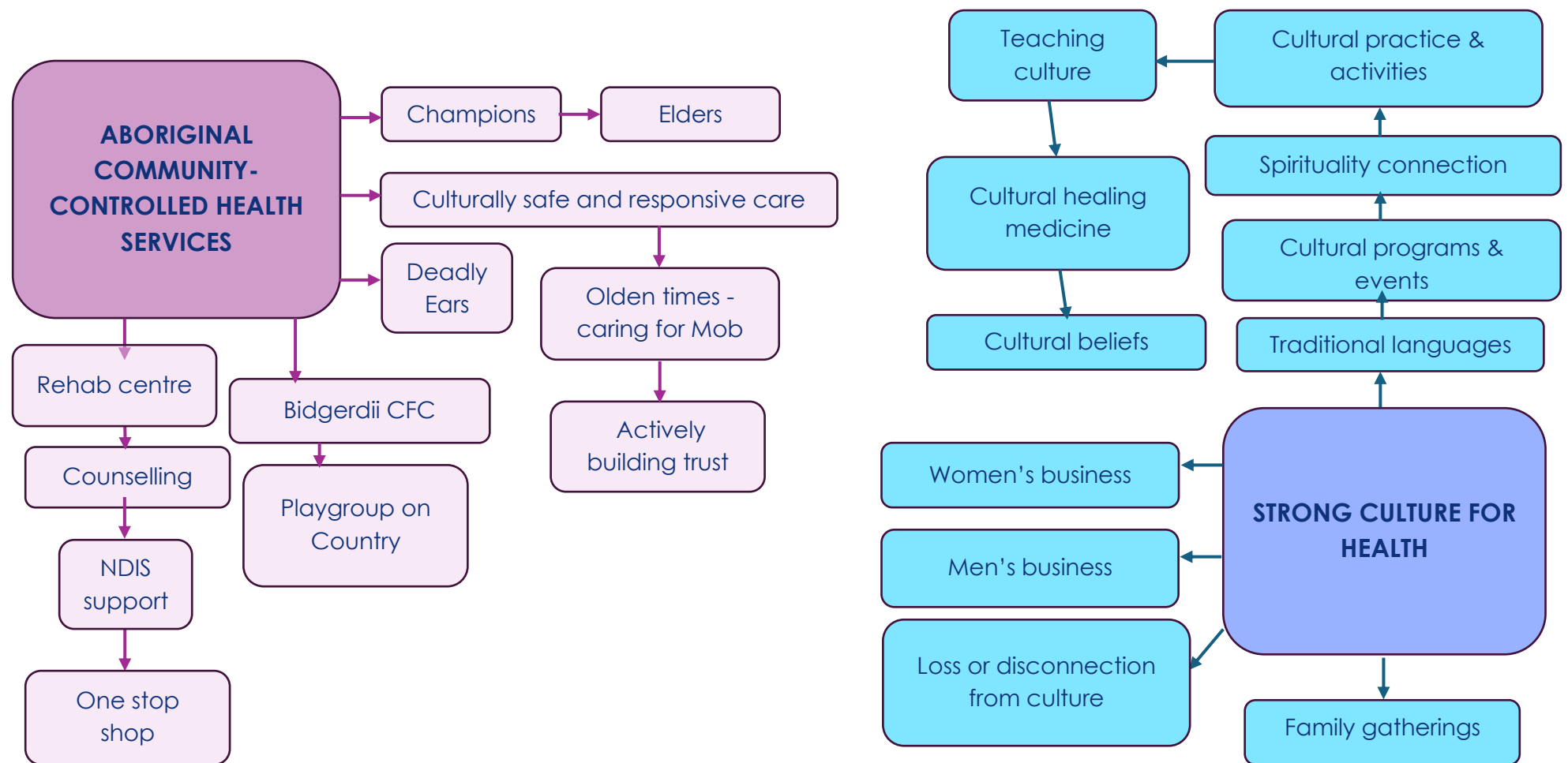


Figure 7 a) Coding framework related to the themes ACCHS, and b) STRONG CULTURE FOR HEALTH

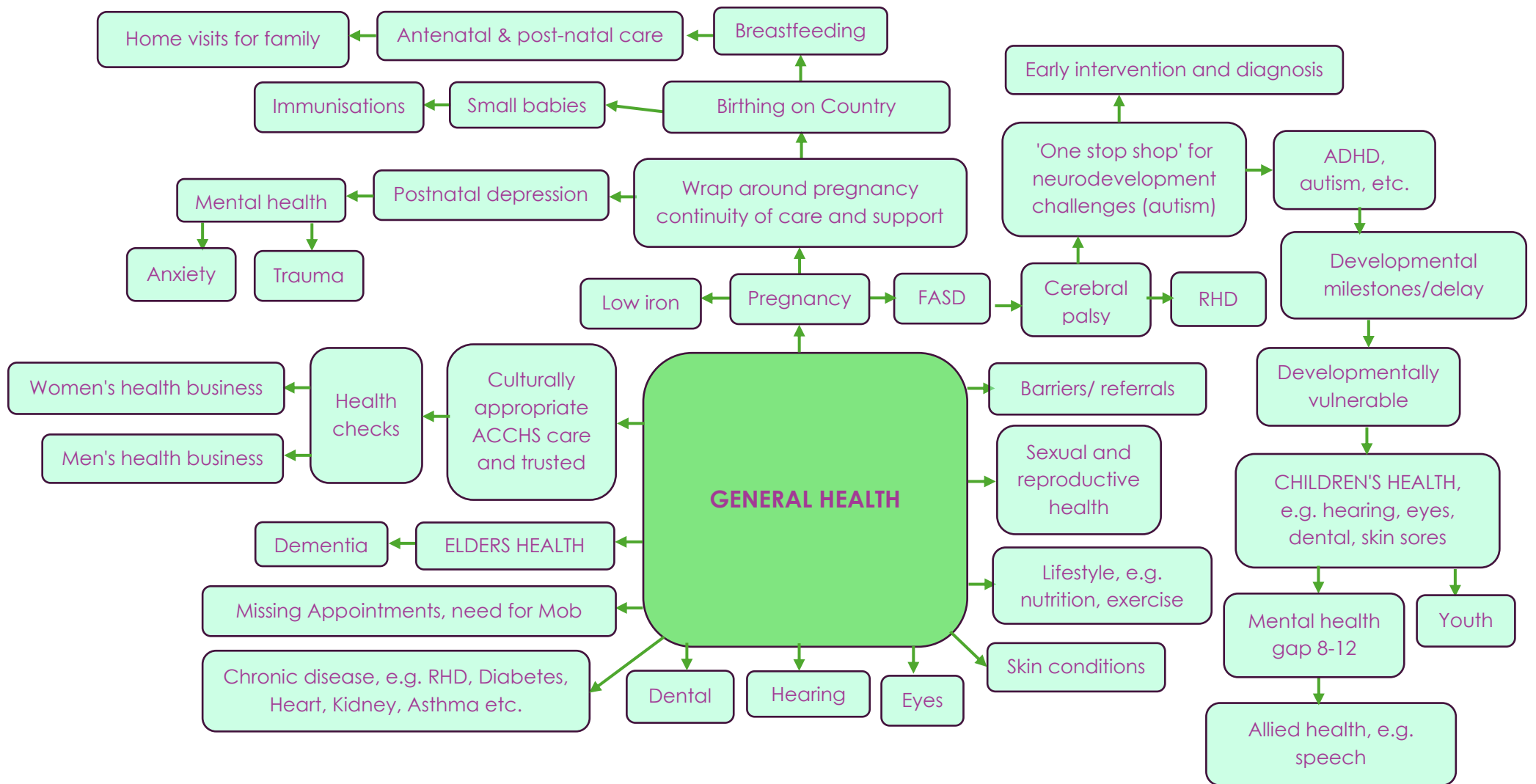


Figure 8 Coding framework related to the themes GENERAL HEALTH

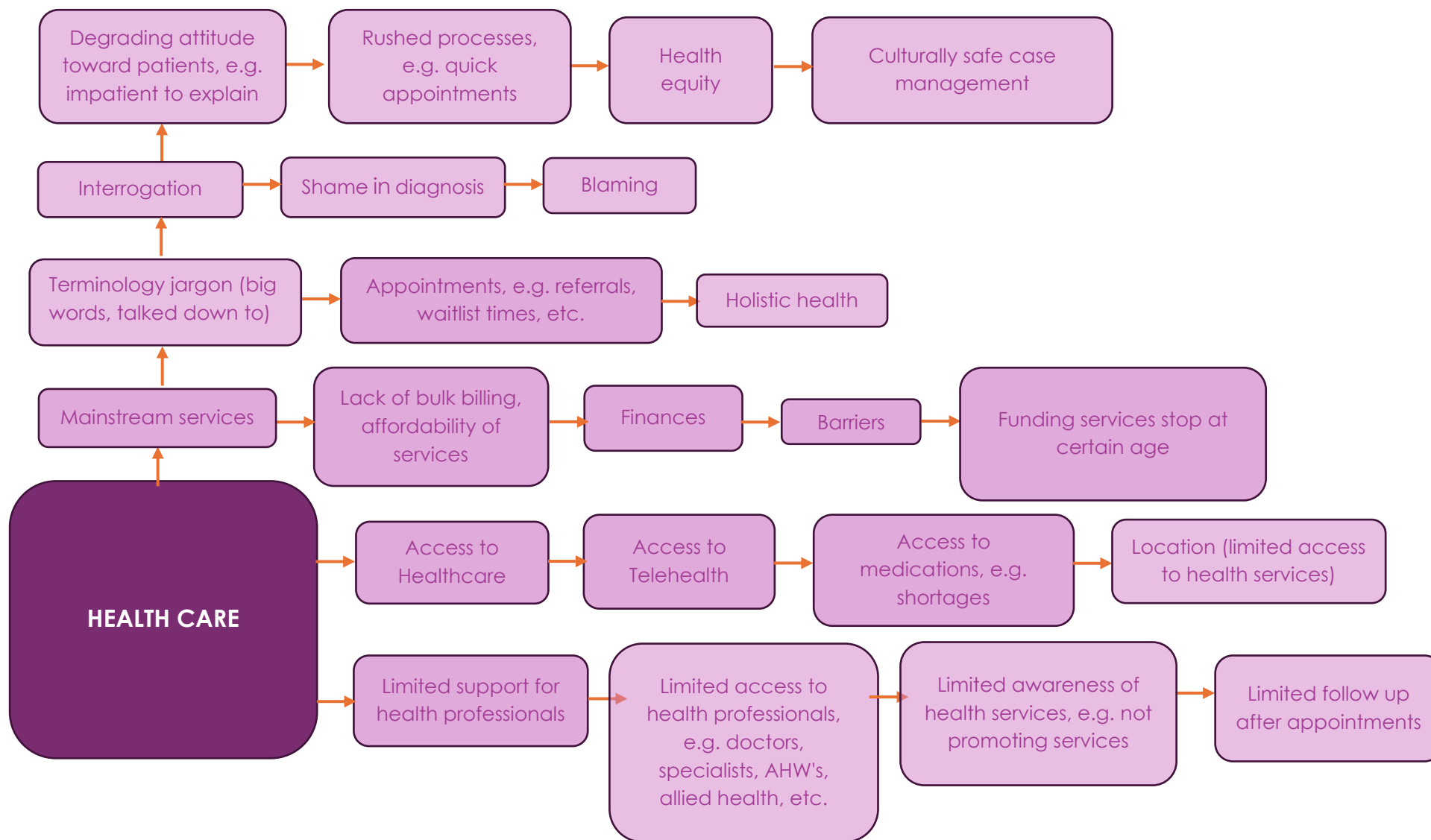


Figure 9 Coding framework related to the themes HEALTH CARE

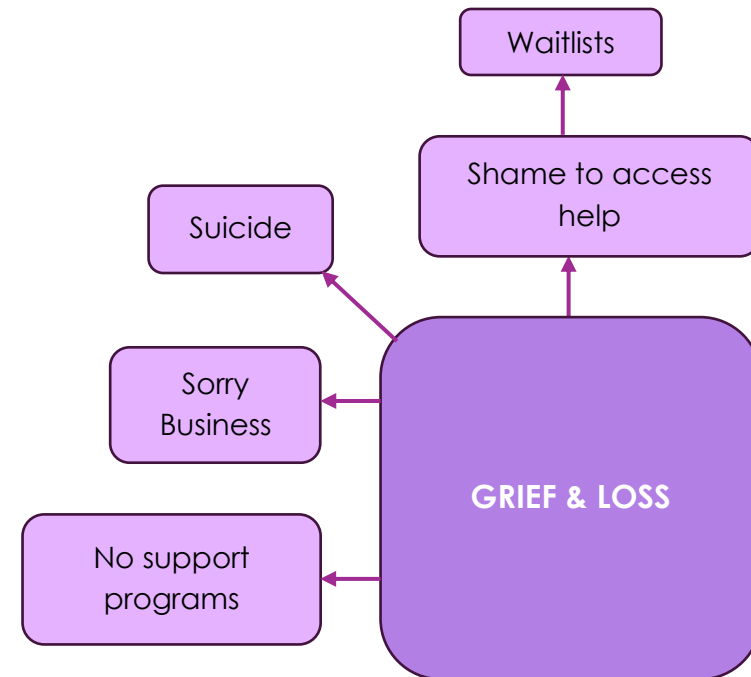
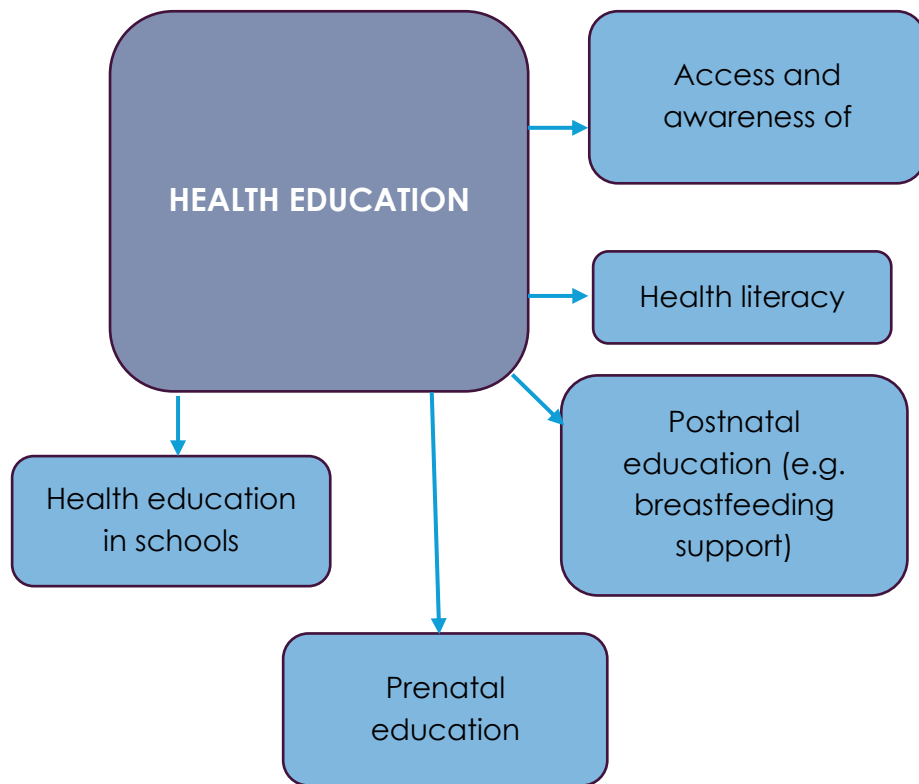


Figure 10 Coding framework related to the themes a) HEALTH EDUCATION and GRIEF and LOSS

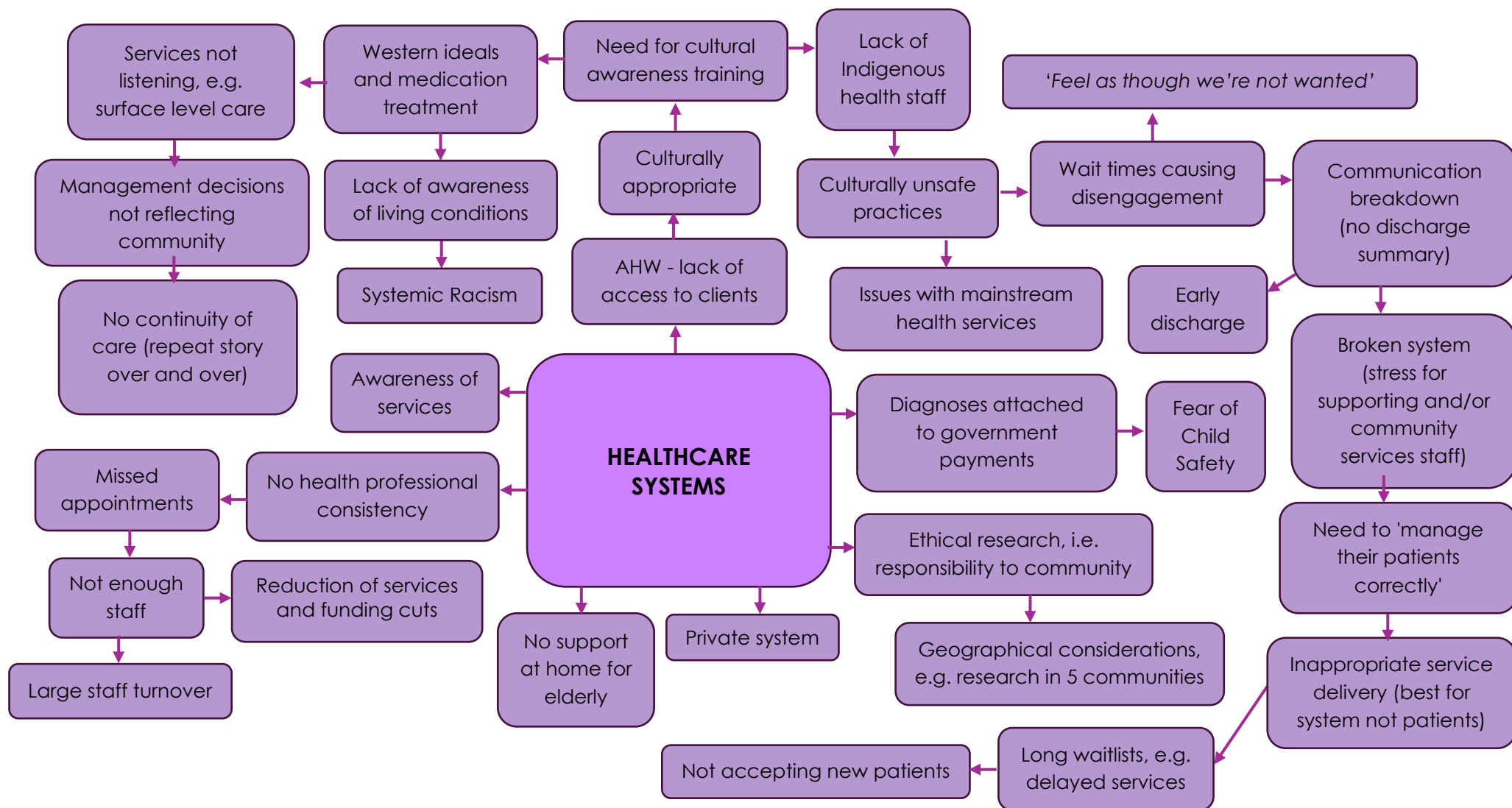


Figure 11 Coding framework related to the themes HEALTHCARE SYSTEMS

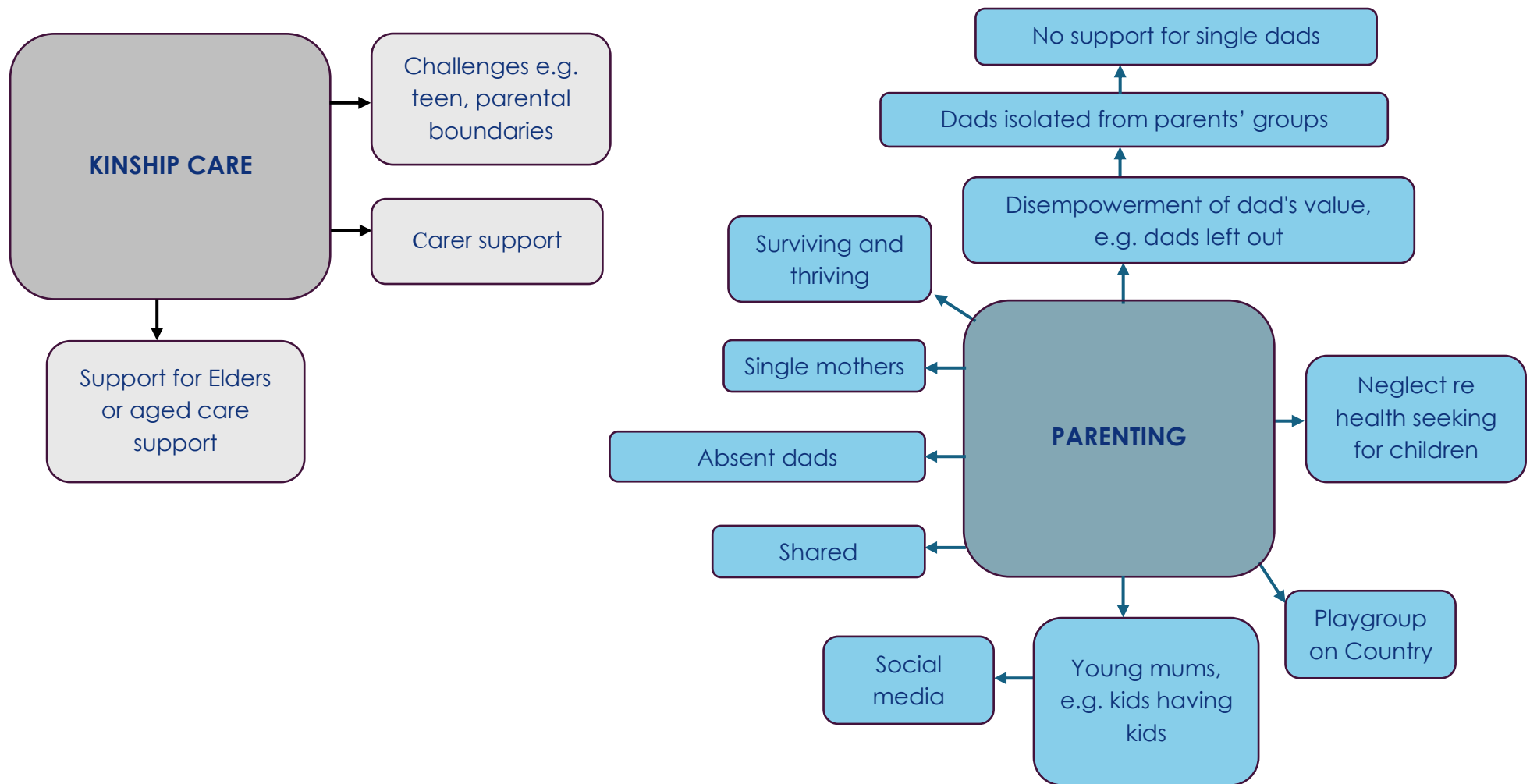


Figure 12 Coding framework related to the themes a) KINSHIP CARE and FAMILY and PARENTING

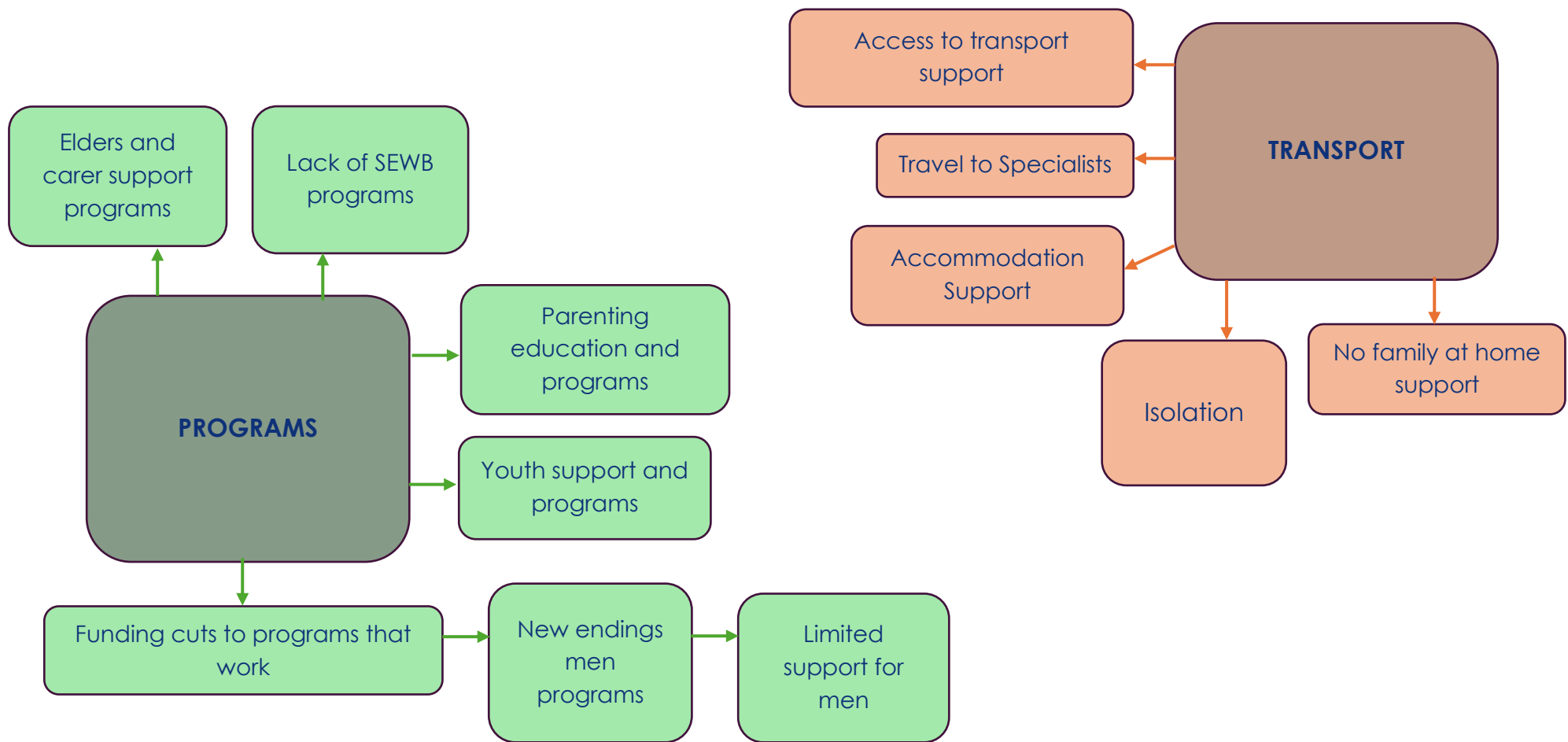


Figure 13 Coding framework related to the themes a) PROGRAMS and TRANSPORT

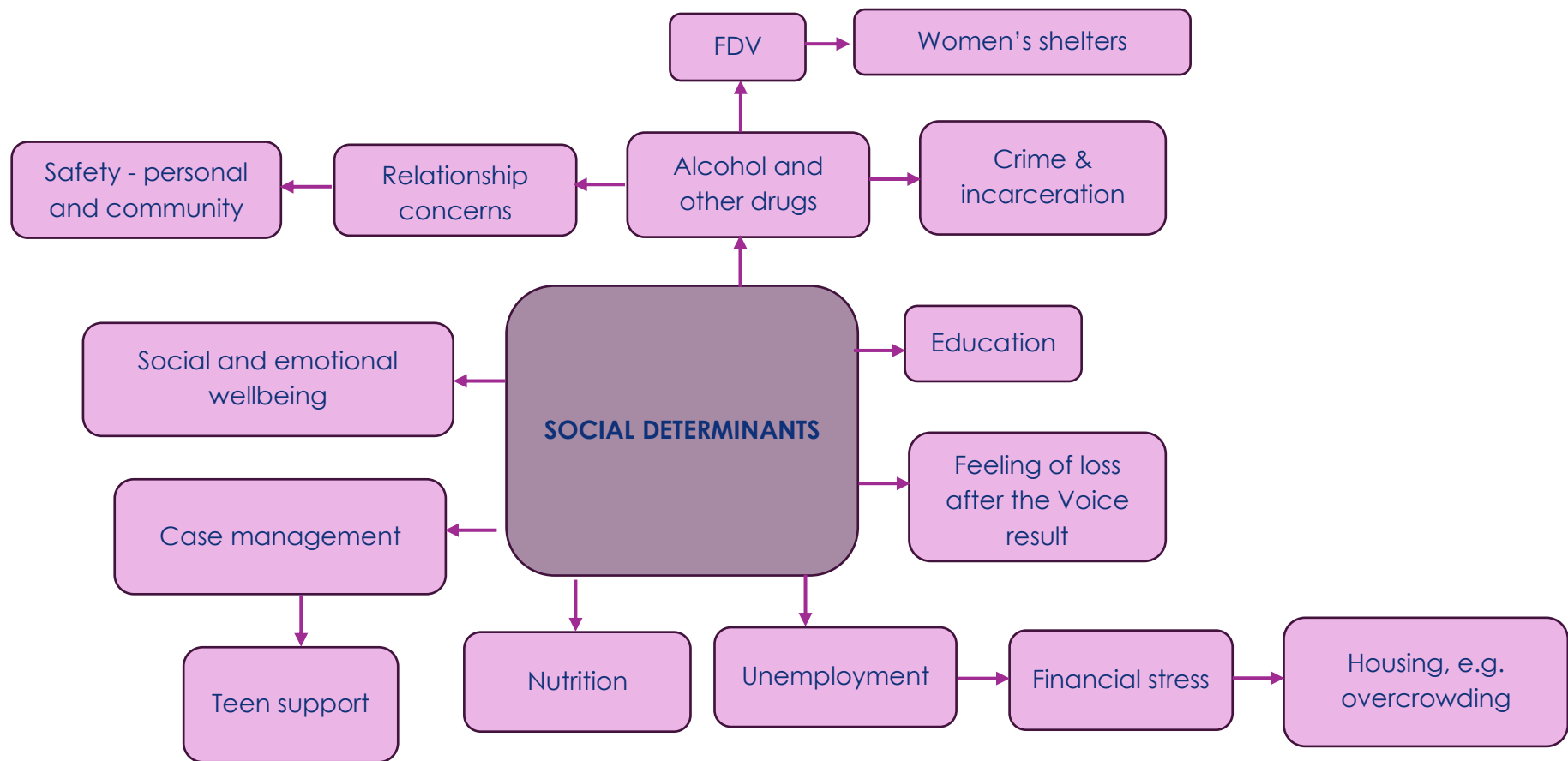


Figure 14 Coding framework related to the themes a) SOCIAL DETERMINANTS