Evaluation of the Australian Government's Investment in Aboriginal and Torres Strait Islander Primary Health Care through the Indigenous Australians' Health Programme

Monitoring and Evaluation Design Report: Appendices

26 July 2018

Contents

Appendix 1: Guiding ethical principles and evaluation standards

This appendix:

1. Lists the principles, ethics and standards that have informed the development of the five ethical principles guiding the evaluation:
    - Including and respecting diverse voices, values and knowledge
    - Building trustworthy and trusting relationships
    - Ensuring equity of power and respecting self-determination
    - Negotiating consent, accountabilities, resources and governance
    - Ensuring benefit and adopting a strengths-based approach.
2. Outlines the rationale for the selection of the five ethical principles.
3. Describes how the five ethical principles will be applied in Phase 2 of the evaluation.
4. Lists the set of standards the evaluation will meet and how we will adhere to key aspects of the standards.

1.1. Documents informing the selection of ethical principles

Guidance	Guidance documents
National Indigenous strategies	The Indigenous engagement principle from the *National Indigenous Reform Agreement 2008* *Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health: A National Approach to Building a Culturally Respectful Health System* *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*, and its *Implementation Plan*
Aboriginal and Torres Strait Islander health research guidelines	*Guidelines for Ethical Research in Australian Indigenous studies,* Australian Institute of Aboriginal and Torres Strait Islander Studies, 2012 *National Statement on Ethical Conduct in Research Involving Humans* (2015) National Health and Medical Research Council (NHMRC) ethical guidelines: 1. *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*, 2003. 2. *Keeping Research on Track: A Guide for Aboriginal and Torres Strait Islander peoples about Health Research Ethics*, 2005

Guidance	Guidance documents
Evaluation ethics and standards (international/Australasian)	*Australasian Evaluation Society's (AES) Guidelines for the Ethical Conduct of Evaluations*, 2010 *Evaluation Standards for Aotearoa New Zealand*, 2015 *Program Evaluation Standards*, The Joint Committee on Standards for Educational Evaluation (JCSEE), 2011
Co-design and consumer engagement principles	*Draft Guidance on Co-producing Research*, by INVOLVE

Each of these documents are discussed and referenced in the following section.

1.2. Rationale for selection of ethical principles

From an analysis of the documents listed above, we identified the following five key ethical principles:

1. Including and respecting diverse voices, values and knowledge
2. Building trustworthy and trusting relationships
3. Ensuring equity of power and respecting self-determination
4. Negotiating consent, accountabilities, resources and governance
5. Ensuring benefit and adopting a strengths-based approach.

These informed the evaluation co-design phase (Phase 1) and will inform the implementation of the evaluation (Phase 2). The rationale for highlighting each of the five ethical principles includes:

1. Including and respecting diverse voices, values and knowledge

- The first principle of the Australian Institute of Aboriginal and Torres Strait Islander Studies' *Guidelines for Ethical Research in Australian Indigenous Studies* is 'recognition of the diversity and uniqueness of people, as well as of individuals, is essential'.[1]
- NHMRC's *Keeping Research on Track* highlights that different Aboriginal and Torres Strait Islander communities will have their 'own established and respected values and protocols, and unique ways of expressing their different values' (p.8).[2]
- Two of the five principles from the *Draft Guidance on Co-producing Research* are also focused on the inclusion of all voices and respecting and valuing the knowledge of all involved.[3] This document also highlights reciprocity, as does the *Evaluation Standards for Aotearoa New Zealand* as part of its second principle – ethic of care, the other four being care, respect, inclusion and protection.[4]

2. Building trustworthy and trusting relationships

- NHMRC's *Values and Ethics* highlights the need to develop ethical, trusting relationships, which recognise difference in values and culture. 'Working with difference … takes time, care, patience and the building of robust relationships' (p.3). Further, 'the soundness of trust among [the research] stakeholders is essential to a

successful and ethical outcome. Trust has to function at all levels…' – between the participants, evaluators, commissioners of the evaluation, applicable sector, academia, government and the wider community. 'Trust and ethical behaviour are not just about rules but also about discretion and judgement – both complex and challenging matters' (p.3).[5]

- The importance of building respectful, meaningful relationships is also highlighted as the first principle in the *Evaluation Standards for Aotearoa New Zealand* and in the *Draft Guidance on Co-producing Research*.
- Transparency will be key to developing such relationships. NHMRC's *Values and Ethics* highlights that 'trustworthiness… is a product of engagement between people [which involves] transparent and honest dealing with values and principles' among other things (p.4).[6] The *Indigenous engagement principle* supports the need for transparency 'regarding the role and level of indigenous engagement along a continuum from information sharing to decision-making' (refer to Section 3.1).[7]

3. Ensuring equity of power and respecting self-determination

- The *Draft Guidance on Co-producing Research* highlights 'equity of power' as the key principle from which all their other principles – respecting and valuing the knowledge of all involved, inclusion of all voices, reciprocity, building and maintaining relationships – follow. The draft states that addressing the range of social, economic and historical power inequalities will be an ongoing endeavour. The transparency principle will require clear differentiation about when participants are able to 'influence' decisions and 'make' decisions.
- The *Cultural Respect Framework* highlights the importance of focusing on cultural safety and responsiveness when gathering data, information, and undertaking planning, research and evaluation (p.17).[8]
- The second principle of the *Guidelines for Ethical Research in Australian Indigenous Studies* is that 'the rights of indigenous people to self-determination must be recognised'.[9] This is followed by several principles highlighting the importance of recognising and/or respecting, protecting and maintaining the rights of Indigenous peoples to their intangible heritage, their traditional knowledge and cultural expressions, and their Indigenous knowledge, practices and innovations.

4. Negotiating consent, accountabilities, resources and governance

- Principles 6 to 9 of the *Guidelines for Ethical Research in Australian Indigenous Studies* the foundations for research with or about Indigenous peoples', 'responsibility for consultation and negotiation is ongoing', 'consultation and negotiation should achieve mutual understanding about the proposed research' and 'negotiation should result in a formal agreement for the conduct of a research project'.[10]
- The *Evaluation Standards for Aotearoa New Zealand* talk about identifying, acknowledging and negotiating the accountabilities of all stakeholders (evaluation commissioners, evaluators, participants and other users) to each other and their respective communities and organisations, at the beginning and throughout the evaluation.

- The *Evaluation Standards for Aotearoa New Zealand* also highlight the need to ensure there are sufficient resources to undertake the evaluation, and for its governance to be negotiated between those who have authority in the context of the evaluation (e.g. commissioners, evaluators, community elders, local organisational managers).

5. **Ensuring benefit and adopting a strengths-based approach**

- Principles 11 and 12 of the *Guidelines for Ethical Research in Australian Indigenous Studies* are 'Indigenous people involved in research, or who may be affected by research, should benefit from, and not be disadvantaged by, the research project' and 'research outcomes should include specific results that respond to the needs and interests of Indigenous people'.[11]
- The NHMRC's *Values and Ethics* highlights ensuring 'research outcomes include equitable benefits of value to Aboriginal and Torres Strait Islander communities or individuals. Reciprocity requires the researcher to demonstrate a return (or benefit) to the community that is valued by the community and which contributes to cohesion and survival. … Aboriginal and Torres Strait Islander communities have the right to define the benefits according to their own values and priorities' (p.10).[12]
- The *Cultural Respect Framework* suggests that evaluation enables the targeting of areas, strategies, policies, programs and services that 'evidence tells us will achieve the greatest impact' (p.17).[13]
- Closing the Gap – Refresh is focused on 'moving to a strength-based approach… that celebrates Indigenous achievement as well as addressing persistent disadvantage'.[14]

1.3. Application of the ethical principles in Phase 2

The following table describes how Phase 2 of the evaluation will adhere to the five ethical principles.

Principles	Evaluation
Including and respecting diverse voices, values and knowledge	The evaluation recognises the diversity and uniqueness of people and communities. A large number of sites (20–24 sites) will enable greater potential to cover the heterogony between Aboriginal and Torres Strait Islander communities, along with diversity of population groups and circumstances across Australia. The wide range of engagement points in the evaluation – the site studies, national and state/territory engagements, collaboratives, governance arrangements and technical experts – creates many opportunities for the inclusion of diverse voices, values and knowledge. The highly participatory nature of the evaluation design – co-design, co-creation sessions and collaboratives – will ensure Aboriginal and Torres Strait Islander values, perspectives and experiences are central to the design, data-gathering, analysis, interpretation and reporting of the evaluation findings.

Principles	Evaluation
	Aboriginal and Torres Strait Islander people have been, and will be, involved in senior, governance, leadership and other roles across the design and all implementation stages of the evaluation. The dignity, inherent value, wisdom, knowledge, skills and experience of all those involved in the evaluation will be respected.
Building trusting and trustworthy relationships	The four-year timeframe of the evaluation entails long-term, collaborative relationships to be developed across all levels – community people, providers, other sector stakeholders, evaluators, and with the evaluation commissioner. The establishment and maintenance of relationships will build on those initially developed in the evaluation design phase through engagement with Health Partnership Forum members in seven state and territories. Honesty and transparency regarding roles, levels of engagement, decision-making, resources and information will be a cornerstone practice. Sufficient lead-in time has been allocated to approach sites and seek their participation in a mutually beneficial relationship. The relationships will be sustained through regular contact that works for the sites. The evaluation design has flexibility to respond to changing local changing circumstances and life events.
Ensuring equity of power and respecting self-determination	Addressing the range of social, economic, historical and political power inequalities in our interactions, methodological and analytical approaches will be an ongoing endeavour throughout the evaluation. It will be supported by the national and site governance structures, technical experts and the formal ethics process, along with culturally safe evaluation and research practice. All evaluation team members working with Aboriginal and Torres Strait Islander participants will either be Aboriginal or Torres Strait Islander people trained in evaluation or research, have extensive experience working in Aboriginal and Torres Strait Islander primary health care settings, or will work in partnership with people who have these attributes. The rights of Aboriginal and Torres Strait Islander people to self-determination is recognised in several ways, including honouring the principle 'nothing about us, without us', the use of a culturally meaningful definition of 'health', 'inviting' not presuming participation in the evaluation, working with local governance structures, and respecting ownership and guardianship of knowledge, data and resources. Specific data principles and protocols will be established as part of the establishment phase and ethics approval process.
Negotiating consent, accountabilities, resources and governance	Negotiation and free, prior and informed consent will underpin all engagements with Aboriginal and Torres Strait Islander people, communities, providers and other stakeholders. At a site-level, sufficient time and visits have been built into the evaluation design to firstly present information about the evaluation, and if a site chooses to participate, then negotiate and formally document the

Principles	Evaluation
	agreement in an MOU. This will include respective accountabilities, a tailored site evaluation plan, the appropriate times and forms of engagement, data-gathering and communication processes, sharing and dissemination of findings and evaluation reports. The evaluation team will seek advice as to who has authority to negotiate in each context. A similar process will be followed for the national and state/territory engagements. Negotiation processes will be ongoing through annual co-design planning and reflection on how well and useful the evaluation processes are. The evaluation will be resourcing the evaluation tasks and activities, including some potential actions that may arise from the co-creation and collaborative sessions.
Ensuring benefit and adopting a strengths-based approach	The purpose of the evaluation is to strengthen the PHC system, health and wellbeing outcomes, and the participation of Aboriginal and Torres Strait Islander people in Australian society. The evaluation has been designed to create multiple opportunities across the PHC system from the policy to practice level, for the evaluation participants to identify and act on improvements. The evaluation will provide recent, analysed data and facilitated data making meaning (as part of the co-creation and collaborative sessions) to enable better informed decisions, for providers, national and state/territory stakeholders. The evaluation will provide facilitated forums for stakeholders (co-creation and collaborative sessions) to come and work together to problem solve and identify solutions and action plans. It will also provide resourcing for supporting the implementation of actions, such as providing training or knowledge expertise. The evaluation reporting will facilitate up-to-date horizontal and vertical information flows across the PHC system. The evaluation will work from a strengths-base, highlighting and sharing success as well as challenges.

1.4. Evaluation standards and their application

As described in the Monitoring & Evaluation Report, the evaluation will adhere to the five Program Evaluation Standards[15] – utility, feasibility, propriety, accuracy and evaluation accountability. These are widely recognised by professional evaluation organisations, including the Australasian Evaluation Society, and are intended to increase the quality of evaluation practice.

The table below shows how the evaluation will meet all 30 of the Program Evaluation Standards.

Standard statements	How the standard will be met
Utility – The utility standards are intended to increase the extent to which stakeholders find evaluation processes and products valuable in meeting their needs.	
U1 Evaluator Credibility Evaluations should be conducted by qualified people who establish and maintain credibility in the evaluation context.	The evaluation will include highly experienced evaluators, Aboriginal and Torres Strait Islander researchers and evaluators, PHC experts, and people with substantial experience working within the program and community context in which the IAHP operates.
U2 Attention to Stakeholders Evaluations should devote attention to the full range of individuals and groups invested in the program and affected by its evaluation.	The evaluation will engage with interested individuals and groups at different levels of the health system, including people in communities (both those who use and those who do not use PHC services), service providers and health workers, and national and state/territory level stakeholders.
U3 Negotiated Purposes Evaluation purposes should be identified and continually negotiated based on the needs of stakeholders.	The evaluation purposes have been informed by engagement with the DOH, the HSCG and stakeholders in the wider community as part of the evaluation design phase. Additional purposes for site-based studies will be negotiated with stakeholders in these sites and confirmed in an MOU. Purposes will be continually revisited in governance discussions at both a national and site level.
U4 Explicit Values Evaluations should clarify and specify the individual and cultural values underpinning purposes, processes, and judgements.	Criteria for informing values-based (evaluative) judgements will be made explicit and be informed by evidence collected to answer the evaluation question 'What do Aboriginal and Torres Strait Islander people value in terms of service delivery and design?'.
U5 Relevant Information Evaluation information should serve the identified and emergent needs of stakeholders.	The information needs of the evaluation commissioning organisation and other stakeholders have been widely canvassed during the design phase. The evaluation has been designed using repeated 'Plan-Do-Study-Act' cycles to enable an explicit response to emerging stakeholders' needs over its four-year lifespan.
U6 Meaningful Processes and Products Evaluations should construct activities, descriptions, and judgements in ways that encourage participants to rediscover, reinterpret or revise their understandings and behaviours.	Joint co-creation and collaborative sessions with evaluation participants will provide meaningful opportunities for reflection, interpretation and re-interpretation, and for identifying meaning and significance of data and findings.

Standard statements	How the standard will be met
U7 Timely and Appropriate Communicating and Reporting Evaluations should attend to the continuing information needs of their multiple audiences.	Data reports, reports on co-creation sessions and annual evaluation reports (including summaries) will be provided to evaluation participants. Progress reports will also be provided to the DOH to inform annual planning processes. A communications strategy (see Section 8 of the Monitoring & Evaluation Report) will inform wider stakeholder communication.
U8 Concern for Consequences and Influence Evaluations should promote responsible and adaptive use while guarding against unintended negative consequences and misuse.	Through the 'Plan-Do-Study-Act' cycle and a proactive communications strategy, the evaluation design has a deliberate focus on participants identifying appropriate actions in response to emerging findings. Mechanisms to guard against negative consequences and misuse include having the evaluation process continually negotiated with and governed by a range of participants, continually testing the emerging findings and their interpretation, ensuring the values and criteria informing evaluative conclusions are transparent, and utilising a strengths-based approach.
Feasibility – The feasibility standards are intended to increase evaluation effectiveness and efficiency.	
F1 Project Management Evaluations should use effective project management strategies.	To ensure the evaluation is undertaken effectively and efficiently there will be a project sponsor and evaluation team leader, a dedicated project manager and an administrator all of whom will utilise project management timeline, budget and reporting systems.
F2 Practical Procedures Evaluation procedures should be practical and responsive to the way the program operates.	The wide systems-focus stakeholder engagement and the breadth of the evaluation design will enable a practical and comprehensive investigation of the ways the IAHP operates in different contexts. Adaptations of specific design elements and the proposed data will occur as part of tailoring the design at the local/regional, state/territory and national levels, and with data experts within the DOH and externally.
F3 Contextual Viability Evaluations should recognise, monitor, and balance the cultural and political interests and needs of individuals and groups.	The evaluation will pay attention to understanding the cultural, political and historical context of the IAHP. The evaluation team will continue to monitor communications in the Aboriginal and Torres Strait Islander PHC sector and attempt to balance cultural and political interests associated with evaluation participants and stakeholders. Any concerns about the feasibility of balancing cultural and political needs and interests will be discussed with the HSCG and the CCG.

Standard statements	How the standard will be met
F4 Resource Use Evaluations should use resources effectively and efficiently.	The inclusion of specific project management expertise and strategies will ensure evaluation resources are utilised effectively and efficiently. Explicit discussion will occur with participants to ensure their involvement is resourced, that reciprocity occurs and that no undue burden is created by the evaluation.
Propriety – The propriety standards support what is proper, fair, legal, right and just, human rights and respect in evaluations.	
P1 Responsive and Inclusive Orientation Evaluations should be responsive to stakeholders and their communities.	Further to standard statement 'U2 Attention to stakeholders', the evaluation will deliberately seek inclusion from individuals and groups who may not normally participate in such processes. This includes both vulnerable populations, such as people within the criminal justice system, and family groups or Indigenous organisations that are often overlooked.
P2 Formal Agreements Evaluation agreements should be negotiated to make obligations explicit and take into account the needs, expectations, and cultural contexts of clients and other stakeholders.	Formal MOUs will be negotiated, documented and agreed with national, state/territory and site-based stakeholders. Site-based MOUs will avoid the use of jargon, and instead use community communication norms and requirements.
P3 Human Rights and Respect Evaluations should be designed and conducted to protect human and legal rights and maintain the dignity of participants and other stakeholders.	Refer to the table in 1.3 on how the principles of the evaluation will be applied.
P4 Clarity and Fairness Evaluations should be understandable and fair in addressing stakeholder needs and purposes.	A range of communication channels will be used, including the use of visuals and text, to inform stakeholders about the evaluation. These will be piloted before broad use. Stakeholder' needs and purposes will be negotiated as part of the engagement process and revisited annually (or as needed) throughout the evaluation. A range of stakeholder governance mechanisms will be implemented to ensure fairness.
P5 Transparency and Disclosure Evaluations should provide complete descriptions of findings, limitations, and conclusions to all stakeholders, unless doing so would violate legal and propriety obligations.	The evaluation team will maintain open lines of communication with stakeholders, and explain and disclose information in an understandable and culturally appropriate way. Annual evaluation reports, with full descriptions of interim findings, limitations and conclusions, will be shared with all participants and published on the project website, subject to legal and propriety obligations.

Standard statements	How the standard will be met
P6 Conflicts of Interests Evaluations should openly and honestly identify and address real or perceived conflicts of interests that may compromise the evaluation.	Real or perceived conflicts of interest will be identified and addressed as a standing item on the agenda during each of the governance sessions with the HSCG, CCG and site governance forums. The evaluation team will immediately raise any such issues with the DOH.
P7 Fiscal Responsibility Evaluations should account for all expended resources and comply with sound fiscal procedures and processes.	The evaluation provider has the necessary project and financial management systems and processes in place to ensure accountability for expended resources and compliance with sound fiscal procedures and processes.
Accuracy – The accuracy standards are intended to increase the dependability and truthfulness of evaluation representations, propositions, and findings, especially those that support interpretations and judgements about quality.	
A1 Justified Conclusions and Decisions Evaluation conclusions and decisions should be explicitly justified in the cultures and contexts where they have consequences.	The evaluation will engage with a range of stakeholders, particularly Aboriginal and Torres Strait Islander people, in making meaning of findings and identifying actions (e.g. through the co-creation and collaborative processes). This will help to ensure different values are reflected in the way the findings and conclusions are justified.
A2 Valid Information Evaluation information should serve the intended purposes and support valid interpretations.	Further to A1 actions supporting the validity and multi-cultural validity of the interpretations, there will be a transparent recording of all information sought and gathered to address the evaluation purposes, objectives and questions.
A3 Reliable Information Evaluation procedures should yield sufficiently dependable and consistent information for the intended uses.	Considerable investigation will be undertaken into the feasibility and reliability of the quantitative data used for the evaluation. The evaluation team applying the qualitative data methods will undergo training to ensure an appropriate balance is reached between being responsive to people/presenting circumstances and ensuring consistency in the information gathered.
A4 Explicit Program and Context Descriptions Evaluations should document programs and their contexts with appropriate detail and scope for the evaluation purposes.	The evaluation will describe and analyse the IAHP and its context at the national level, including mapping out the program's resources (how and where funding has been distributed), as well as detailed service/program mapping at the site level. The evaluation will also track and describe changes in the program and its context over the four years.

Standard statements	How the standard will be met
A5 Information Management Evaluations should employ systematic information collection, review, verification, and storage methods.	The evaluation provider has systems in place for systematic and secure storage of information. Quantitative data protocols will outline the processes for systematic collection, review and verification of numerical data. Qualitative data methods will include the development and use of guides and protocols, and the review and verification of information gathered by team members. There will be several opportunities for participants to review and verify the information via the provision of summary notes and discussion at co-creation sessions and meetings of the HSCG and CCG.
A6 Sound Designs and Analyses Evaluations should employ technically adequate designs and analyses that are appropriate for the evaluation purposes.	The evaluation design is the result of an 8-month co-design process with the DOH, HSCG, 26 stakeholder organisations and some community organisations across Australia. The design is informed by literature, experience and ethical guidelines. It has been reviewed by a wide group of people from the DOH and the HSCG. The evolving design will continue to be co-designed and receive input from a Technical Reference Group.
A7 Explicit Evaluation Reasoning Evaluation reasoning leading from information and analyses to findings, interpretations, conclusions, and judgements should be clearly and completely documented.	All reports that include evaluative reasoning will clearly show the line of sight from evidence to conclusions and recommendations/actions. This will enable readers to understand the basis for how these were reached, and to draw alternative conclusions and recommendations from the evidence gathered and analysed. We will make clear distinctions between evidence, analysis and our evaluative judgements.
A8 Communication and Reporting Evaluation communications should have adequate scope and guard against misconceptions, biases, distortions, and errors.	An extensive review process will be undertaken for all evaluation communications and reporting, including as part of an internal quality assurance process, and a review by the DOH, HSCG and members of the Technical Reference Group.
Evaluation accountability – The evaluation accountability standards encourage adequate documentation of evaluations and a meta-evaluative perspective focused on improvement and accountability for evaluation processes and products.	

Standard statements	How the standard will be met
E1 Evaluation Documentation Evaluations should fully document their negotiated purposes and implemented designs, procedures, data, and outcomes.	The evaluation design and co-design process has been fully documented. This will continue into the implementation of the evaluation and include MOUs, tailored evaluation plans, protocols, guides, interview and session summaries, baseline and annual data reports, analyses, and progress and annual reports. There will be an explicit focus on capturing process learnings from the evaluation, including changes generated through the evaluation itself.
E2 Internal Meta-evaluation Evaluators should use these and other applicable standards to examine the accountability of the evaluation design, procedures employed, information collected, and outcomes.	The evaluation team includes senior, experienced evaluators who regularly apply these and other evaluation standards in the normal course of their work and via peer review of other team members' work.
E3 External Meta-Evaluation Program evaluation sponsors, clients, evaluators, and other stakeholders should encourage the conduct of external meta-evaluations using these and other applicable standards.	The evaluation team will establish a group of technical advisors to provide external advice and review of evaluation processes and products. This will include experts in, for example, systems evaluation and the interpretation of Indigenous statistics.

Appendix 2: Health Sector Co-design Group

This appendix outlines the membership of the Health Sector Co-design Group and provides the full Terms of Reference for the group.

2.1. Membership

Name	Role and organisation
Kate Thomann (Co-chair)	Assistant Secretary, Primary Health Data and Evidence Branch, Indigenous Health Division, Department of Health
Dr Mark Wenitong (Co-chair)	Senior Medical Advisor, Apunipima Cape York Health Council
Karen Visser	Director, Strategy Investment, Data and Evaluation Section, Primary Health Data and Evidence Branch, Indigenous Health Division, Department of Health
Kim Grey	Senior Adviser, Information and Evaluation Branch, Indigenous Affairs, Department of the Prime Minister and Cabinet
Jessica Yamaguchi	Adviser, Information and Evaluation Branch, Indigenous Affairs, Department of the Prime Minister and Cabinet
Dr Fadwa Al Yaman	Head, Indigenous and Children's Group, Australian Institute of Health and Welfare
Dr Dawn Casey	Chief Operating Officer, National Aboriginal Community Controlled Health Organisation
Angela Young	General Manager, Policy and Research, Queensland Aboriginal and Islander Health Council
Karl Briscoe	Chief Executive Officer, National Aboriginal and Torres Strait Islander Health Worker Association
Janine Mohamed	Chief Executive Officer, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
Professor Norm Sheehan	Director, Gnibi College of Indigenous Australian Peoples, Southern Cross University
Dr Jeanette Ward	Consultant, Public Health Medicine, Kimberley Population Health Unit, Western Australia Country Health Services
Nicki Herriot	Chief Executive Officer, Northern Territory PHN
Vacancy	

2.2. Terms of Reference for the Health Sector Co-design Group

Purpose

The role of the Health Sector Co-Design Group is to work collaboratively with the Allen + Clarke team (the evaluation team) to help facilitate a robust and high-quality evaluation design and the implementation of this design.

Functions

The HSCG will:

- provide advice on the wider co-design and stakeholder engagement process
- be engaged as co-designers in the evaluation design itself
- review and provide feedback on key deliverables
- advise the Department of Health and the Minister for Indigenous Health on the approval of the evaluation design
- continue to provide advice, guidance and leadership in relation to implementation of the evaluation.

It is expected that the HSCG will continue through the evaluation implementation period, although its function may change. Should the functions of the HSCG change, this Terms of Reference will be adjusted in agreement with the HSCG.

Perspectives

Members of the HSCG are not expected to 'represent' specific agencies or organisations, geographic areas, or population groups. The aim is for members to advise based on their expertise, experience and 'place' within the health system, or on their knowledge of evaluation and research with Aboriginal and Torres Strait Islander people and health.

Co-chairs

The HSCG is to be co-chaired, with one co-chair from the government sector and the other in a non-government role, and for at least one of the co-chairs to be an Aboriginal or Torres Strait Islander person. The co-chairs do not have different powers to other members of the HSCG. They are to be the key point of contact for the evaluation team and for the DOH, and will help the evaluation team to facilitate strong input from all other members of the HSCG. The co-chairs own advice on the approval of the evaluation design will be considered as equal to other members of the HSCG.

Acceptance of deliverables

The DOH remains responsible for accepting reports and other deliverables and making related payments to Allen + Clarke.

Secretariat

Meeting papers will be circulated in advance of meetings. Secretariat support will be provided by Allen + Clarke. This support includes arranging for and paying the costs of members' travel for face-to-face meetings.

Confidentiality and conflicts of interest

The evaluation team and the DOH are to highlight any information that is shared confidentially and to remain in confidence within the HSCG. Members will be asked to declare any actual, potential or perceived conflicts of interest at each meeting.

Proxies

Ideally no proxies (stand-ins for members) are to be used, but the HSCG will also be respectful of, and flexible regarding, members' circumstances. By exception, the HSCG will decide if it is agreeable for a stand-in at a particular meeting. Part of the process for accepting a proxy is that the proxy member will be fully briefed in advance of the meeting.

Remote attendance will also be utilised where possible, when members are unable to attend in person.

Use of videos and photographs

Permission will be sought from the HSCG or members as appropriate, when videos of activities and/or photographs are taken during the meeting. These are not to be used for purposes other than recording events and information for the evaluation team to use in designing the evaluation, unless permission is sought and given. If other uses are proposed, e.g. for public communications about the HSCG and the evaluation, permission will be sought from the HSCG and/or affected members as appropriate.

Inclusion of HSCG membership in communications

The HSCG has given permission to share the names of HSCG members in early communications about the evaluation on the proviso the wording is checked with the HSCG beforehand.

Organisational communications

HSCG members agree to take responsibility for keeping their organisations fully informed of the evaluation.

Fees and expenses

Members will not receive sitting fees, but travel and accommodation expenses will be provided.

Appendix 3: Summary of stakeholder engagement

This appendix lists the organisations which participated in Phase 1 of the evaluation and summarises what the range of stakeholders said is important for the evaluation design.

3.1. Stakeholders providing input into the evaluation design

Stakeholder organisation	Number of participants
National organisations	**9**
Australian College of Rural & Remote Medicine	2
Department of the Prime Minister and Cabinet (Health Branch)	3
National Aboriginal Community Controlled Health Organisation	1
National Aboriginal and Torres Strait Islander Health Worker Association	1
Royal Australian College of General Practitioners	2
New South Wales	**3**
Aboriginal Health & Medical Council of New South Wales	1
Department of Health (State Office)	1
Ministry of Health (New South Wales Government)	1
Northern Territory	**16**
Aboriginal Medical Services Alliance Northern Territory	4
Department of Health (Northern Territory Government)	5
Department of Health (Territory Office)	3
Department of the Prime Minister and Cabinet (Regional Office)	3
NT Primary Health Network	1
Queensland	**19**
Brisbane North PHN	1
Brisbane South PHN	6
Department of Health (State Office)	4
Department of Health (Queensland Government)	4
Queensland Aboriginal and Islander Health Council	4
South Australia	**14**
Aboriginal Health Council of South Australia	5
Adelaide PHN	3
Department of Health (State Office)	3
Department for Health and Ageing (Government of South Australia)	1
Department of the Prime Minister and Cabinet (Regional Office)	2
Tasmania	**10**

Stakeholder organisation	Number of participants
Department of Health (State Office)	3
Department of Health and Human Services (Tasmania Government)	4
Primary Health Tasmania	2
Tasmanian Aboriginal Centre	1
Victoria	**20**
Department of Health (State Office)	3
Department of the Prime Minister and Cabinet (Regional Office)	4
Victoria PHN Alliance	9
Victorian Aboriginal Community Controlled Health Organisation	4
Western Australia	**12**
Aboriginal Health Council of Western Australia	3
Department of Health (Government of Western Australia)	3
Department of Health (State Office)	4
Department of the Prime Minister and Cabinet (Regional Office)	1
Western Australia Country Health Service (Government of Western Australia)	1
TOTAL	**103**

3.2. What people told us is important for this evaluation

Throughout Phase 1, the evaluation team canvassed the views of a range of stakeholders in the evaluation through co-design meetings, and community and stakeholder engagement. This section summarises the views of the stakeholders listed in section 3.1 above by the main areas of enquiry, and key themes about *how* the evaluation process should be undertaken.

There was a high level of engagement by key stakeholders in the meetings. Awareness of the proposed evaluation varied from those who had not heard about it before we contacted them to others who had been anticipating an opportunity to provide input for some time. People asked a lot of questions about the evaluation (e.g. 'will it cover x?'), and were clearly not used to being consulted at a point in the design stage at which we could turn their questions around (e.g. 'do you think that should be covered in the evaluation?').

Neither did the stakeholder engagement occur in a vacuum as stakeholders had recently engaged in consultations on *My Life My Lead* to shape the next Implementation Plan for the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* and the CtG – Refresh. There were also announcements during the course of the engagements on a new IAHP funding methodology, and DOH grant management teams within State Offices were preparing to shift to the Department of Social Services' Community Hubs from 1 July 2018. Nevertheless, stakeholders were highly engaged in our discussions and largely enthusiastic about the opportunity the evaluation presented.

3.2.1. Purpose and use of the evaluation

It was common for stakeholders to reflect on the complexity of the PHC system and to voice hope that the evaluation could be used to inform greater system coherence, coordination, alignment and simplification. This included coherence in areas of national-level structural policy and leadership (e.g. from Closing the Gap, COAG, framework agreements, the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023,* funding systems and nKPIs), down to simplification of who funded and delivered what services on the ground: 'How do we promote system integration when we don't know what's in the system?'. A related theme was the hope that the evaluation would help bring greater transparency to flows of PHC funding (i.e. who receives what, from where).

Some stakeholders also hoped the evaluation could be useful in determining local-level health and wellbeing needs and priorities, so as to enable the system to move from a reactive mode (where priorities are determined by who walks through the door) to more proactive models of care. The opportunity to learn from providers who were performing well in this area was also noted. Through this, it was hoped, providers would be better placed to develop ideas and plan population-level health services, as well as to think more innovatively and laterally about how they could respond to known health needs. It would also enable more targeted funding of needs, priorities and proven practices.

Some stakeholders saw the evaluation as an opportunity to inform future monitoring and reporting requirements on the IAHP, and the wider PHC system, that further incorporated outcome indicators (with less focus on outputs) and qualitative reporting. It was also seen as an opportunity to support the capability of the sector to undertake internal or self-evaluation (e.g. within PHNs or ACCHSs) and to provide and use data.

Within the community controlled sector specifically, stakeholders thought the evaluation might be able to demonstrate the benefits of community control, and to identify poor performing areas so that state sector agencies and others could better target their support for system strengthening.

More generally, there were calls for the evaluation to establish a stronger evidence base for investment in PHC, and to serve a problem-solving function that focused on facilitating solutions to long-standing and emergent needs at different levels, from national policy and planning to local service delivery. With the greater emphasis on social and cultural determinants of health within the next Implementation Plan, the evaluation could also provide evidence about how best to tackle these determinants.

Some stakeholders did express concern that the evaluation would be used to inform decisions on reducing funding levels, and called for the DOH to be clear in explaining why it was evaluating the IAHP and how the information would be used.

3.2.2. Areas of focus

There were a lot of ideas gathered about what the evaluation should focus on, from high-level concepts to specific issues of concern often related to elements of the Aboriginal and Torres Strait Islander PHC system.

At the higher level, there were calls for the evaluation to look beyond the IAHP by taking a whole-of-system approach focusing on system linkages, how the various parts of the IAHP fit/work together, and the influence of social and cultural determinants of health such as housing, education and employment. It also included the opportunity of learning from where things might be working well in other sectors and applying these to the PHC system.

There were strong calls for the evaluation to cover the total IAHP investment and not just focus on service delivery. It was common for stakeholders to report the need for the evaluation to 'shine the torch on' the IAHP in terms of the DOH's policy and grant management processes and business systems: 'Have we got the policy settings right?'. People expressed the need for the evaluation to ask whether the program is designed well to begin with, and then whether it is being delivered according to a strong design.

There was also a suggestion to look at different grant management processes within the IAHP, including those which stakeholders considered had more support wrapped around them and gave the funder greater assurance by 'protecting its investment' (e.g. the National Best Practice Unit supporting implementation of the Tackling Indigenous Smoking program). Related to this, were calls to examine what difference more/less prescription in funding makes (recognising some components of the IAHP offer more flexibility than others). Within the context of the pending shift of grant management to the Department of Social Services' Community Hubs, there were requests for the evaluation to look at whether the management of grants remained aligned with policy intentions under the new regime.

Some stakeholders felt the evaluation should consider the adequacy of funding, and the alignment between available funding and expectations around comprehensive PHC. Related to this was a view that it would be helpful to focus on the extent to which overburden in the sector was affecting the effective implementation of the IAHP.

A further high-level response was the need for the evaluation to focus both on what is working well and on what is not working so well, as long as this is done constructively.

More specific areas of enquiry that stakeholders identified included:

- Workforce issues – including workforce supply and retention, the employment of Aboriginal and Torres Strait Islander people, cultural competency of the workforce in mainstream services, and, more broadly, the roles of a PHC team and how to ensure good training for those roles.
- Capability within the system, including workforce and IT capability around data collection, analysis and reporting.
- A focus on understanding non-participants – who is missing out on primary care and why.
- Understanding how different models of PHC (including more/less integrated models, different models of community control, etc.) align with local community aspirations, the reality of funding and servicing remote populations, and good practice.
- The influence of cultural safety and racism on health service delivery and outcomes for Aboriginal and Torres Strait Islander people.
- Sustainability and governance of ACCHSs – understanding whether approaches to community control are always the best ones or whether we are setting up services to fail, with inadequate support for capacity building and unrealistic expectations for, in particular, services in remote areas.

Several stakeholders suggested the need for the evaluation to describe what has happened under the IAHP, including what has changed from previous Australian Government approaches to investing in PHC for Aboriginal and Torres Strait Islander people. In this way, the evaluation can

check on whether and how the IAHP has addressed issues that were previously considered problematic.

3.2.3. Values that need to be considered

The fundamental feedback on the values that the evaluation would need to consider in judging the success of the IAHP was that success must always be framed from where someone sits in the system. In other words, community/consumer expectations and aspirations for PHC must be incorporated into the framing of success. It is worth noting that the stakeholders we engaged with, as part of the agency consultation, included many Aboriginal or Torres Strait Islander people who may have provided views both as health sector experts and as consumers of health services.

Stakeholders provided the following, more specific, input as to what they expected from the evaluation:

- To consider measures beyond health service coverage and health status, citing other important values such as quality and experience of care.
- To value and measure wellness, rather than having a sole focus on illness.
- To be cognisant that some communities/consumers will have low expectations of the health service/system and that this may affect how they describe what they value about it.
- To take into account how different models of PHC reflect community aspirations.
- To assess the wider value associated with having an Aboriginal and Torres Strait Islander health workforce (i.e. people in employment), beyond any influence on consumer experience, care and outcomes.
- To consider values associated with empowerment, self-determination and local control.

3.2.4. Important settings and contexts

Important settings or contexts that stakeholders felt the evaluation should consider can be grouped in three areas: system, service and population. As well as the high-level points noted here, stakeholders spoke to other settings that were specific to a state/territory.

System contexts

The main theme at the system level is 'change'. Many states and territories had had a recent change in government as a result of elections, which meant that policy settings around health and other key areas such as self-determination were in a state of flux with the intended direction not always clear. The other major changes at the system level, as discussed earlier, are the shift in IAHP grant making from the DOH to the Department of Social Services' Community Hubs (so IAHP policy and grant making will sit in different federal agencies), and the new IAHP funding methodology.

The evaluation will also need to recognise the varied governance and leadership arrangements across states and territories, including, for example, state/territory governments having different roles in PHC, Health Partnership Forums having slightly different membership and function, and the existence of regional multi-stakeholder forums around PHC in some states/territories.

Service contexts

At a service level, the main issue raised by stakeholders was the need for the evaluation to cover different service models/settings. This included regional services, regional consortia of providers, hub and spoke services, homeland services, ownership and control models (community controlled models, government managed services, private general practice, NGO services, etc.), fly in/out models of care, and medical services vs health services vs more integrated services covering a range of sectors.

Stakeholders also suggested that a key determinant of effectiveness, and therefore a factor to consider in selecting sites for study, is the level of service provider maturity and sophistication.

Population contexts

Stakeholders identified a range of population groups they felt that the evaluation needs to include, such as young people (mid-20s and 30s where early intervention is critical for chronic disease), prisoners, people with disability, the LGBTI population and transient people (e.g. who discharge from hospital but live remotely).

There was also a view that the evaluation needs to consider populations facing barriers to services through remoteness, due to distance, and other 'hard to get to' factors such as poor transport connections. In addition, it was suggested that the evaluation should include community settings where there is both strong Aboriginal or Torres Strait Islander leadership, and strong traditional settings (e.g. connection to land).

3.2.5. Evaluation methods and processes

Stakeholders provided valuable advice to inform the design of the evaluation methods, including the need:

- To utilise existing information, including data that is already reported into the system and information collected in other recent evaluations and consultations. It was felt this information could be re-purposed for the evaluation, thereby adding value to what has already been collected through making meaning and research translation processes. In addition to widely recognised data and information, stakeholders provided specific examples of data that some providers, researchers or funders have collected that may not have been reported to DOH, as well as local service and patient journey mapping exercises that have been undertaken.
- To build on the strengths of existing systems and processes, such as CQI collaborative processes and mechanisms for agencies, including state sector agencies, to support system strengthening.
- To report data and emerging findings quickly and efficiently to providers and communities.
- To provide local contextualisation of data.
- To build in approaches both to reciprocity and capacity building that support people and organisations to engage in the evaluation, and to reducing the burden of participation.
- To acknowledge that information is not always shared effectively between agencies by providing clarity on which parts of the system the evaluation is focused.

- To take a flexible approach given that the IAHP may not be stable over the proposed four-year lifetime of the evaluation.
- To exercise care in the use of terminology and not to assume that communication works well across the sector.
- To consider how any systems or processes developed as part of the evaluation (e.g. around making meaning and learning) can be sustained beyond its lifetime.

One stakeholder, who has had experience with the co-design of programs in the Aboriginal and Torres Strait Islander health sector, provided specific input relevant to the co-design aspect of the evaluation methodology:

- One way to consider 'co-design' is for this to occur 'under Aboriginal or Torres Strait Islander leadership'.
- Co-design is about 'working off the same song-sheet' with the community. You do not need to lead the co-design, as much as create a vehicle for it.
- In co-design, there is a need to work with the community to identify, define and unpack the 'real' problem, as an initial step.
- It is important to be honest about what you are co-designing and what you will deliver.
- The people you bring together for the problem identification process might be different to those who co-create the solutions – Aboriginal and Torres Strait Islander leadership can change depending on what the task is.

Another stakeholder identified some useful lessons in terms of 'what worked' from a previous large-scale evaluation of a complex initiative in which they had been involved. These included ensuring rapid feedback to services and community, face-to-face engagements, sessions with stakeholders from across the DOH to make meaning of emerging findings, and recognising the value of qualitative data and methods when quantitative data might be of poor quality.

Stakeholders also provided specific advice on potential sites for system-based site studies, and suggested that Health Partnership Forums should be consulted on site selection. They also referred the evaluation team to other resources and contact people, and offered to disseminate Phase 2 of the evaluation through their communication channels.

Appendix 4: Key issues of relevance from the literature

This evaluation design is informed by a synthesis of available evidence and theoretical foundations for the current range of primary health care programs, in particular key Government documents including the *National Aboriginal and Torres Strait Islander Health Plan, 2013–2023*; *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023*; *IAHP Theory of Change: Indigenous Australians' Health Programme – Program Theory;*[16] *IAHP Programme Guidelines; Indigenous Advancement Strategy*; and *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*.[17] In addition, a range of research papers, conference proceedings and publications were reviewed. This includes, but was not limited to, the following focus areas.

4.1. Evaluation in the context of Aboriginal and Torres Strait Islander people's health

Guidelines for Ethical Research in Australian Indigenous Studies[18] and the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health*[19] outline principles to ensure that research with and about Aboriginal and Torres Strait Islander people follows a process of meaningful engagement between the researcher and the individuals and/or communities involved.[20] It must also recognise, protect and advance the rights, cultures and traditions of Aboriginal and Torres Strait Islander people.[21,22] The importance of methodological approaches to evaluation that value and build on Indigenous expertise, existing community strengths, assets and knowledge systems is emphasised.[23]

The recently published *Indigenous Advancement Strategy Evaluation Framework* distils these principles into a framework for developing and conducting evaluation to generate high-quality evidence, strengthen partnerships and Indigenous leadership in evaluation, build capacity, foster collaborative and continuous learning, and facilitate service improvement and local decision making. In practice, this requires participatory methods with Indigenous communities and appropriate processes for collaboration with Aboriginal and Torres Strait Islander Australians.[24]

The *Indigenous Advancement Strategy Evaluation Framework* and broader literature underlines the need to respond appropriately to diversity within Indigenous communities, including the diverse health needs of Aboriginal and Torres Strait Islander people and communities, and their differing views about evaluation and concepts of 'success'.[25,26,27,28] Some groups require tailored forms of engagement, for example, those not using health services, transient populations, children and youth, incarcerated people, and some people living with disability. This requires provision for additional, in-depth, customised approaches.[29] Some communities have less capacity or inclination to engage, including those that may have become cynical about the ability of governments to change and where there is insufficient support for participation and capacity building.[30] Indigenous PHC services themselves are diverse in location, governance, resources and capacity, and thus may need different levels of support to engage.[31]

The value of place-based approaches is highlighted in recent literature, particularly where a high level of engagement and trust is achieved. In these approaches, care is taken through local, participatory and iterative processes to negotiate access to local-level data, to understand context and together make sense of the data, and to create opportunities for adaptive management and service improvement.[32,33,34] Achieving this level of trust and participation takes time, people with the right skills, good communication and leadership by all parties, governance support,

appropriate resources, clarity about processes, roles and responsibilities, mutually agreed outcomes and the steps to achieve them, and a willingness to share responsibility for progress.[35]

If successful, these processes go some way towards addressing issues raised in the context of Indigenous data sovereignty. The United Nations Declaration on the Rights of Indigenous Peoples recognises the rights of Indigenous peoples to self-determination (Article 3), and this extends to self-government and autonomy in relation to internal and local affairs (Article 4).[36] These articles underpin an inherent right to control over the collection, ownership and application of data about them.[37]

Australian sociologist Maggie Walters observes the long-standing pattern of deficit framing Indigenous people through data that problematises them. She also makes the point that the power and the politics of data are embedded in the 'who' and the 'what': for example, who has the power to make the assumptive determinations as to what is problematic, what it is that requires investigation, which objects should be interrogated, which variables tested, and what is the significance of available and missing data.[38] She discusses expanding the 'recognition space' between Indigenous and non-Indigenous understandings, so that Indigenous people 'speak back to the state in the language of statistical evidence that they both understand and culturally respect, and reframe the narratives about us'.[39]

Similarly, in recent speeches and articles Professor Ian Anderson, Deputy Secretary for Indigenous Affairs at the Department of the Prime Minister and Cabinet, highlights a need to democratise data,[40] as this 'will help drive empowerment for local communities so that they can tell their own stories and make decisions using their own data'.[41] He advocates for greater Indigenous leadership and capability around data analysis and research, recognising the power of data as an Indigenous asset with the potential, through evidence and research, to drive policy that improves outcomes for Aboriginal and Torres Strait Islander Australians.[42]

4.2. Understanding health care as a complex system

Health care systems and primary care services, including general practice, are increasingly understood to be components within complex social systems.[43,44,45] Complex systems are composed of networks of interconnected components that influence each other, often in a non-linear fashion.[46] The outcomes generated from such a complex system cannot be understood by looking at elements within the system in isolation.[47] Access to services, experience and outcomes are best viewed as emerging from the interaction of historical factors, socio-economic conditions, personal and community resources, health service design and values, relationships, resourcing, geography and demographics, among others.[48]

There is an extensive literature on evaluation of interventions in the context of complex systems, including developmental evaluation in the Australian context.[4950] Evaluation in this context requires exploration of multiple perspectives, participation by the communities that are intended to benefit from effective PHC, and those who plan, govern, manage, and deliver primary care. There is value in participatory 'sense-making' processes as a way to incorporate elements of context, wider systems influences and health system dynamics,[51] and the ability to deal with uncertainty but develop plausible explanations and adaptive evaluation approaches.[52]

The IAHP can also be viewed as a health system strengthening program. The literature on suitable methods and techniques to generate evidence of effectiveness in health system strengthening highlights the complexity of undertaking such evaluations. A recent, comprehensive international report reiterates the value of the use of data by stakeholders for learning, promotes the use of

theory of change and mixed methods to generate evidence, and emphasises the importance of understanding context.[53] The authors note the challenges in assessing attribution, given that causal linkages between intervention and impact may be unclear, multiple or indirect. There may also be a substantial time lag between implementation and the anticipated health system outcome and impact, difficulty in identifying which of many factors are playing significant roles in observed change, and the need to consider how the activity *contributed* to the changes observed, given the complexity of attribution.[54]

The Sentinel Sites Evaluation is a particularly useful and relevant Australian example of an evaluation of a complex intervention aimed at improving prevention and management of chronic disease among Aboriginal and Torres Strait Islander Australians. This evaluation took a place-based approach, with geographically bound sites purposively selected to include a wide range of different contexts across Australia. It included 24 'sentinel sites' with varying degrees of intensity of data collection and analysis, and took a cyclical and place-based approach, involving both local and national level stakeholders in cycles of reflection and feedback. It also drew on principles of realist evaluation and on systems thinking to help draw out how different components of the programs linked together and played out in different contexts. In addition, there was a strong focus on the usefulness of the evaluation to stakeholders and on program improvement. The Sentinel Sites Evaluation provides rich and practical insights, including the value of 'place' as the unit of design and analysis with which to evaluate the effectiveness of multi-programs, and the value of sustained relationships, trust and cyclic, interactive engagements to gather, use and make sense of data.[55,56]

4.3. Primary health care

NACCHO contextualises comprehensive primary health care as a culturally anchored concept that requires an intimate knowledge of the community and its health problems, active community participation to address these health problems, and promotive, preventative, curative and rehabilitative services.[57] There is a rich literature on what constitutes effective and comprehensive primary health care, enablers and barriers to good care, and what Indigenous Australians value about primary health care.[58,59,60,61,62,63] This includes work to identify the core elements of PHC required to achieve equity of access in rural and remote Australia.[64,65]

There is a useful body of literature that examines the impact of the policy, contracting and funding environment on the ability of PHC providers to improve Indigenous health and reduce inequity.[66] Particular issues highlighted are funding levels, approaches to contracting, the reporting burden, a lack of useful data from reporting and how the scope of comprehensive PHC is defined or interpreted.[67,68,69,70,71] The literature provides examples of evidence of innovation and achievement in PHC through established and new pathways, the development and progress of PHNs, the use of new technologies underpinning these developments, and through effective engagement with Indigenous communities.[72,73,74]

Appendix 5: Program theory for the IAHP

The following text is a direct (albeit edited) copy of the program theory and logic for the IAHP, developed by the Department of Health in mid-2015[75]. As such the theory and logic describes the IAHP at that point in time. A key element of the evaluation is to test and refine the program theory and logic for the IAHP.

5.1. Situation

Aboriginal and Torres Strait Islander people experience significantly worse health outcomes that non-Indigenous Australians. The Indigenous Australians' Health Programme (IAHP) aims to improve the health of all Aboriginal and Torres Strait Islander people through a variety of activities focused on local health needs as well as targeted responses to particular health issues and activity across the life course.

The IAHP is implemented as part of a complex system and the Indigenous Health Division in the Department of Health seeks to influence the system more broadly so that it works for the benefit of Aboriginal and Torres Strait Islander people.

5.2. Purpose of articulating a program theory for the IAHP

The IAHP theory of change and program logic is intended initially as an internal divisional tool to help bring about a shared vision of how the IAHP is supposed to work to achieve its objectives. The theory is intended to enable staff to see how their work links to the bigger picture of what the program is trying to achieve. It provides a tool to inform program implementation, refinement and policy development to ensure that our efforts are best directed to addressing needs and improving outcomes. It will also form the basis for identifying the Indigenous Health Division's strategic evaluation priorities.

The theory of change and program logic will assist in evaluation design and scoping work, not just in terms of assessing the effectiveness of the IAHP at the service system or client levels, but also in terms of the Indigenous Health Division's policy influence in the whole-of-department and government context. It is intended that sub-measures of the IAHP areas will map the overarching theory of change and that a series of layered theories will be produced that will also help inform the design of future evaluations.

A longer term goal is that the theory of change be used externally as a communication tool, for example, when working with other government agencies and stakeholders to bring about improvements in Indigenous health policy, system and services.

5.3. How to read this program theory

The program logic for the IAHP is an outcomes chain logic model. In other words it focuses on results. The diagram reads from bottom to top, beginning by articulating the assumptions, context and external factors for the program. It is intended that each outcome statement (i.e. reading from left to right from the specific level of activity/outcome) should lead consequentially to the next, with each 'stream' eventually contributing to the three high level outcomes at the top and interacting with one another as they go.

The theory is divided into four streams:

- Policy Framework, which is focused on how the elements of the various government systems at all jurisdictional levels work together to deliver evidence-based strategic outcomes.
- System Level Enablers, which focuses on the key health system building blocks that the IAHP seeks to influence through the resources, inputs and activities that it supports.
- Services System, which applies a systems lens to how the components of the health system work together, including planning, governance and integration.
- Aboriginal and Torres Strait Islander people, which focuses on how Indigenous communities and individuals interact with the various components of the health system.

5.4. Context

- Improving the health and wellbeing of Aboriginal and Torres Strait Islander peoples underpins the Government's priorities of education, employment and safe communities.
- The Council of Australian Governments established a framework for tackling Aboriginal and Torres Strait Islander disadvantage with six targets (2008). Two of these targets relate directly to the health portfolio: to close the gap in life expectancy within a generation (by 2031), and to halve the gap in mortality rates for Aboriginal and Torres Strait Islander children under five by 2018.
- Progress is being made towards closing the gap in health outcomes. There has been a large reduction in deaths due to circulatory disease and a small but significant decrease in smoking rates. There have also been improvements in children being immunised and a reduction in infant deaths.
- However, Aboriginal and Torres Strait Islander people still face a great number of health challenges and experience more illness, disability and injury than other Australians. Indigenous children born today can expect to live shorter lives than non-Indigenous children – 10.6 years shorter for males, and 9.5 years for females. Around two-thirds of the gap is due to long-term health problems.[76]
- The IAHP is implemented as part of a broader complex health system. The program will align with the implementation of the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023,* which focuses on systematic service improvements and addressing geographic disparities. Program implementation will also align with broader health system effectiveness measures, such as electronic health records and the establishment of the Primary Health Networks and the planning and coordination opportunities they represent.

5.5. Key assumptions underlying the program theory

- Major systems reform is needed to drive change so that the Australian health care system is appropriately oriented to the health needs of Aboriginal and Torres Strait Islander people. Concerted and long-term effort is needed across all levels of the health system to bring about the desired changes. The Department, through the IAHP can exercise significant leverage to this end.

- At the service system level, there is wide variation in the local and regional context in which services operate including:
    - the type of service delivery model (for example, community controlled and mainstream)
    - regional support arrangements
    - the size and staffing configuration of the service
    - the availability of other service providers
    - demographic profile
    - the types of activities being implemented (service mix)
    - geography including degree of remoteness.
- Aboriginal and Torres Strait Islander people exercise individual choice about where they access health care and may use Indigenous specific primary health care organisations or mainstream health care (private general practice). However, the availability and choice of health care providers is more limited in remote areas.
- Market failure makes it necessary for the Commonwealth to fund organisations to deliver health services to Aboriginal and Torres Strait Islander people, particularly in remote areas.
- Access to comprehensive primary health care and prevention will improve health outcomes, lower the demand for acute care and improve the cost effectiveness of health care (NB: Access is defined as the opportunity to have health care needs fulfilled). A comprehensive approach to primary health care takes into account the social determinants of health, health inequities, health promotion, illness prevention, treatment and care, community development, advocacy, rehabilitation, inter-sectoral action and population health approaches (addressing the needs of the whole population, not just those who walk through the door).
- Primary health care organisations should be the first point of contact and are well placed to support people through the health system and act as home points of care.
- Aboriginal community controlled health organisations are responsive to community needs through community-based boards.
- There are varying levels of capacity among funded organisations to provide quality care. Therefore, significant policy and program effort needs to be put into driving systems improvements in a way that ensures effective risk management, but also harnesses intrinsic goodwill and motivations of staff. Over time this will drive culture change and greater accountability in Indigenous communities for the operation of the health system.
- The evidence base should continue to be built and shared as it informs policy and program decisions (e.g. investment in the early years).
- The effectiveness and efficiency of funded primary health care organisations will improve over time through the IAHP and its continued refinement in terms of design and implementation.

5.6. External factors that affect the success of the IAHP

There are a range of external factors that affect the success of the IAHP. Given that the main objective of the IAHP is to improve Aboriginal and Torres Strait Islander people's access to health care, the conceptual framework for this access is used as the basis for identifying relevant external factors.[77] This encompasses the interface between health systems and populations.

The health system dimensions of access are: approachability, acceptability, availability and accommodation, affordability, and appropriateness. There are five corresponding abilities that populations need to interact with the system and generate access: the ability to perceive, to seek, to reach, to pay, and to engage.

Key external factors are both within the broader health system, such as workforce, as well as across the social determinants of health, such as education and employment. The influence of these external factors on the success of the IAHP emphasises the need for the Indigenous Health Division to engage with relevant policy areas across the Department of Health as well as government to ensure success. Refer to the table at Attachment A for details.

5.7. Outcome and activity descriptions

Policy framework

The policy framework stream is focused on how the elements of the various government systems at all jurisdictional levels work together to deliver evidence-based strategic outcomes in collaboration with stakeholders and participants in the health system. Its success requires the following enablers to be present:

- a willingness by policy makers to work together and share information freely
- open communication between all participants
- long-term planning supported by robust funding and a willingness to allow initiatives to mature before enacting additional change.

The IAHP provides the policy and funding foundations for Indigenous health to identify priorities and provide authority for a comprehensive PHC approach that includes system integration and coordination between primary, secondary and tertiary care. This informs the implementation of the IAHP and enables the following results and outcomes.

Short-term

- IAHP priorities for health communicated internally and across government and non-government agencies – the program priorities are the foundation for this stream, and it is critical that they are communicated to all stakeholders in the policy space.
- Common understanding is reached as to how IAHP aligns with health and social objectives – this assumes that policy makers at all levels of government, as well as with non-government stakeholders, have a clear understanding of the interactions between the IAHP and the broader policy context. It also assumes that relevant agencies will examine their own initiatives and see how they align.

Medium-term

- More aligned policy, program design, implementation and accountability for Indigenous health – this communication results in a more effective response that takes into account the varied factors and issues relating to the IAHP and to Indigenous health more broadly (across government and non-government sectors). This outcome assumes that agencies' understanding of the IAHP will lead to government and non-government policy participants working together to align their approach to Indigenous health and to coordinate policy development and program implementation.
- Improved strategic alignment of data collection, monitoring and evaluation for system improvement – the assumption underlying this outcome is that aligned policy and programs will result in better data collection, monitoring, evaluation and a willingness to accept responsibility for outcomes.

Long-term

- IAHP has better understanding of needs, drivers and policies affecting the Indigenous health system, service and local levels – this outcome relates to the improved use of data, not just in terms of planning, but also as it relates to continuous quality improvement and needs analysis.
- Informed improvements to Indigenous health policy, system and services – this outcome assumes that as a consequence of holistic data being made available at various levels of the system, and reflective practice occurring, changes will occur that are based on the best available evidence.

System-level enablers

The system-level enablers represent the inputs and resources required for each of the health system building blocks based on the World Health Organization's 2007 health systems framework.[78] The IAHP provides funding for a number of building blocks, while other divisions, such as the Health Workforce Division and the Pharmaceutical Benefits Division, support others (for example, the Workforce and Access to Medicines health system building blocks).

Service delivery

Through the IAHP, the Commonwealth funds organisations (including Aboriginal and Torres Strait Islander Community Controlled Organisations as well as other primary health care services) to provide culturally appropriate, comprehensive primary health care to address the health needs of Aboriginal and Torres Strait Islander people. This includes funding for infrastructure, such as capital works projects.

The IAHP also targets funding to influence the health system to respond to identified key priorities for Indigenous health:

Priority	Measure/area of focus
Child and family health	Better Start to Life – New Directions and Australian Nurse Family Partnership Program

Priority	Measure/area of focus
Chronic disease prevention, detection and management	Tackling Indigenous Smoking Program
Northern Territory disadvantage	Northern Territory Remote Area Investment
High disease burden conditions – oral, hearing and vision health	Specialists and allied health
System integration	Funding contributor to the Primary Health Care networks

Through the IAHP the Commonwealth also provides incentives and targeted funding to general practice to improve Aboriginal and Torres Strait Islander people's access to primary health care.

The IAHP funds the following system-level supports to improve system effectiveness, performance and the quality and safety of care at the local, regional and national level.

Information supports

Supports include funding guidelines, monitoring activity, data collections (e.g. national Key Performance Indicators), evaluation and research.

Governance and leadership

Supports include the National Continuous Quality Improvement Framework and Implementation Plan and funding to support sector governance/leadership capacity building (for example, NACCHO and affiliates).

The IAHP also contributes funding to the PHC networks to promote capacity building to enable system integration between primary, secondary and tertiary care.

Service system

For the services system to work optimally, the following enablers are assumed to be present:

- Ongoing learning, including continuous quality improvement being embedded at all levels of the system.
- Leadership, governance and commitment from system participants.
- A commitment to mobilising systems thinking.
- Shared understanding and accountability.
- Partnerships and collaboration (between health services and with Indigenous communities and between government agencies).

Short-term

- Community needs are incorporated in planning and decision making – this is a foundational element of planning, allowing community preferences and needs to be reflected in decision making at all levels.
- Improved planning for Indigenous population health (national, regional and local) – this outcome is critical for the system stream. It assumes that the approach being adopted by the IAHP will achieve improved planning outcomes to meet health and community needs.

Medium-term

Two streams of medium-term outcomes occur simultaneously.

- Health services are appropriately staffed and staff are supported – this outcome reflects the importance of staff with the right training and support being part of the system. It also speaks to the importance of retaining those staff over the longer term.
- Comprehensive range of services provided – a well-planned and staffed service, with good systems in place, is in a position to provide a comprehensive range of primary health care services, including a population health approach.
- Service providers are brought together through management and referral systems – this outcome assumes that appropriate planning will facilitate the links and communication channels that will underpin the requisite system improvements. It focuses on the system linking service providers, so that referrals can happen seamlessly and patients are not subject to repeated questions.
- Providers exchange technical and cultural information and jointly develop solutions – this outcome is driven by the collaboration of participants in the service system. It assumes that providers have the relevant skills required to deliver it.

The above two streams of results contribute to the following outcomes.

- Health and social services providers collaborate across the care continuum to deliver tailored services – this outcome is focused on ensuring that the various available services, including ancillary (outreach, allied health and specialists) and non-health services, work effectively together to treat all client needs. It assumes that services have the capacity and resources to undertake the planning and collaboration required to deliver this outcome.
- Health services are more accessible – this outcome assumes that effective planning will result in more optimal resource allocation leading to deployment of appropriate services that are made available, approachable, acceptable, and affordable for the target population groups.
- Improved prevention, detection and treatment across the life course – this outcome is focused on ensuring that care is provided at every stage of a client's life, with a particular focus on prevention (including population health approaches) to deal with smaller issues before they turn into acute issues to be treated in a hospital setting.
- Services are improved across the system and lessons are shared and used as part of service improvement – this outcome assumes that reflective practice, open communication and free knowledge exchange will result in the sharing of lessons to inform improvements across the system.

- Services are more effective in creating health and wellbeing – services are synchronised and leveraged so that the various needs of individual clients can be addressed and outcomes are improved.
- Integrated service system is formalised to respond effectively to health needs – once services are working well collectively, a more organised approach will ensure that the gains made in collaboration between the services are not lost over time and that improvement processes are embedded within the culture of all system participants to meet the health needs of clients and the target population.

Aboriginal and Torres Strait Islander people

This stream focuses on the experience of clients and communities within the health system. For the outcomes to be achieved, it is assumed that the following enablers are present:

- Open communication between services and clients.
- Services being part of communities, rather than just providing services to communities.
- Respectful understanding of client perspectives.

Short-term

- Clients are more aware of services, believe they are culturally safe – this outcome is focused on ensuring that clients know that the services they need are available, and that those services are available in ways that are culturally competent.
- Clients access services – this leads to clients using the services that are on offer. It encompasses an ability to perceive the need for care, and the ability to seek, reach, pay for and engage with health care.
- Clients receive quality, sensitive response to need – this leads to clients receiving culturally sensitive, appropriate quality health care to meet their health needs. It relies on the assumption that the care will be of a high quality.

Medium-term

- Clients are motivated to take responsibility for health – this assumes that as their health improves and they see tangible outcomes, clients will take a greater part in driving further improvements, making informed decisions.
- Clients connected with all relevant services to meet needs – this outcome is about how clients will be referred to services that meet their needs, including the needs that might not be within the health system (such as social services). It assumes that the services clients need will be available and appropriate in their geographical area.
- Clients implement personal health and wellbeing advice – this outcome focuses on clients adhering to the Health Plan they have developed with health professionals. It assumes that high-quality, culturally appropriate services will increase the likelihood of this outcome occurring, and that clients have the ability to engage actively in their health care.

Long-term

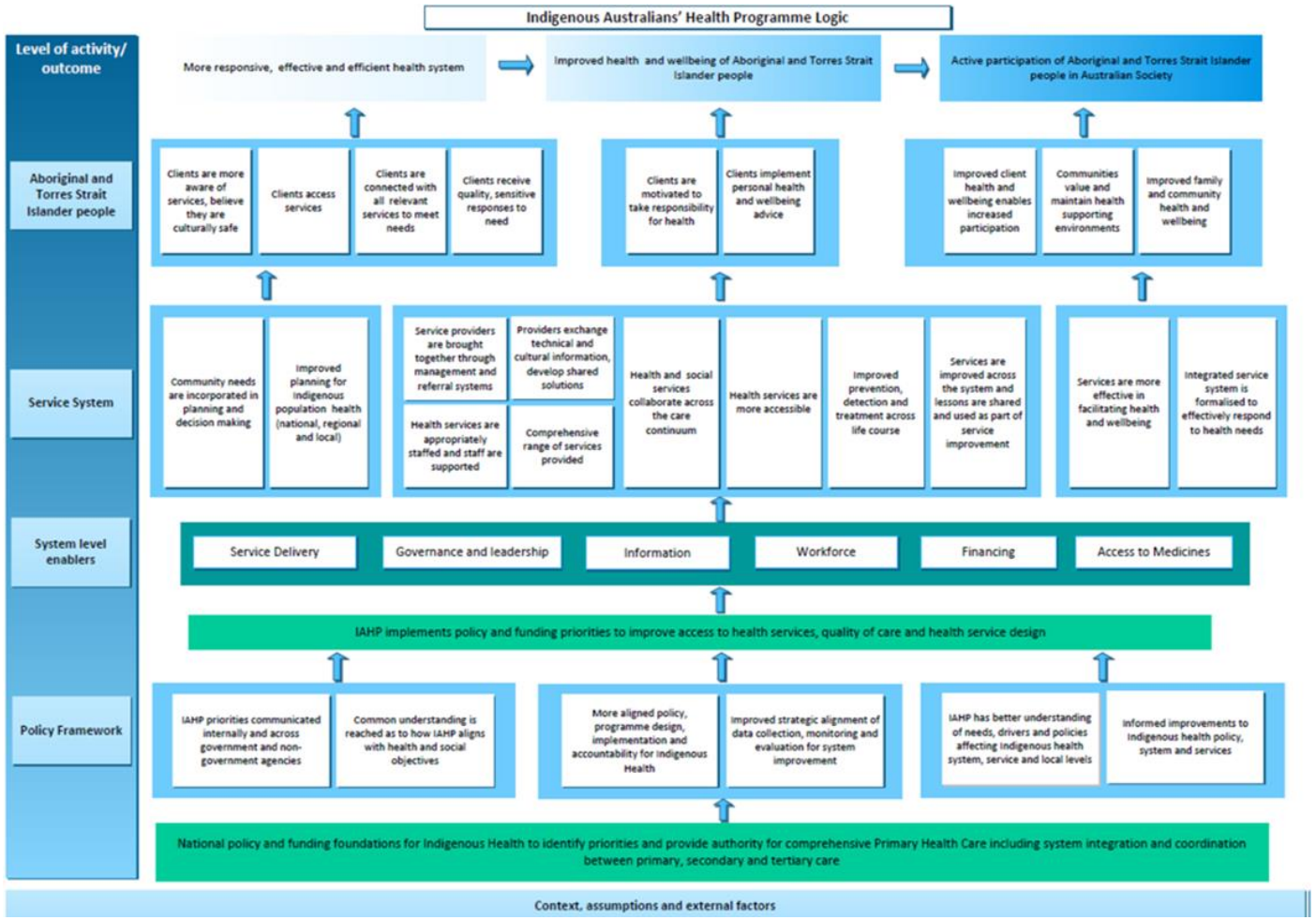
- Improved client wellbeing enables increased participation – this outcome assumes that if a client is experiencing better health outcomes they will participate more meaningfully in a variety of areas, including but not limited to health, education and employment.
- Communities value and maintain health supporting environments – as the health of communities consequentially improves, they will act to ensure that gains are embedded.
- Improved family and community health and wellbeing – this outcome assumes that as a client's health improves it will, in turn, improve the lives of those around them through that person being able to participate and contribute more meaningfully in community life. It also assumes that by demonstrating the outcomes derived from health care services and healthy behaviours, others in the client's social network will be motivated to undertake similar action.

Overarching outcomes

All of the four streams contribute to the overarching outcomes of the IAHP:

- more responsive, effective and efficient health system
- improved health and wellbeing of Aboriginal and Torres Strait Islander people
- active participation of Aboriginal and Torres Strait Islander people in Australian society.

Attachment A – Program Logic



Attachment B – External factors that influence the success of the IAHP

Client	Service	Policy	Responsibility
Ability to perceive the need for health care – health literacy, education	*Approachability* – competent leadership and governance, transparency, outreach	Education	Department of the Prime Minister and Cabinet Department of Education
Ability to seek care – values, culture, autonomy	*Acceptability* – professional values, norms, culture	Workforce Community empowerment	Health Workforce Division Department of the Prime Minister and Cabinet
Ability to reach care – mobility, transport, social support, living environments	*Availability* – location and opening hours	Transport Social services Housing	States Department of Social Services Department of the Prime Minister and Cabinet
Ability to pay for care – income, assets, health insurance	*Affordability of detection and treatment* – costs and resourcing	Employment Social services Medicare Pharmaceutical Benefits Scheme	Department of Employment Department of Social Services Health Benefits Division
Ability to engage with care provider – empowerment, information, adherence, care giver support	*Appropriateness* – qualified workforce with technical and interpersonal skills, information management, coordination and continuity	Workforce IT systems Primary Health Networks	Health Workforce Division E-Health Division Primary Health Care Division

Appendix 6: Evaluation sub-questions by KEQ and health system element

This appendix outlines sub-questions under each of the four key evaluation questions (KEQ), which are organised into questions relating to four health system elements:

- Service delivery
- Population
- Leadership and governance
- Resourcing.

A further sub-question cuts across all of the KEQs under a fifth health system element, Goals:

To what extent is the IAHP contributing to the active participation of Aboriginal and Torres Strait Islander people in Australian society?

KEQ1: How well is the IAHP enabling the PHC system to work for Aboriginal and Torres Strait Islander people?

Service delivery

- To what extent are PHC organisations engaged in an ongoing dialogue with clients and communities about their needs and values and to what extent does this drive service planning and delivery? Is this improving over time?
- To what extent is the PHC service system (including IAHP funded services) oriented and/or becoming more oriented towards Indigenous consumers' values and priorities?
- What is the coverage of health services among Aboriginal and Torres Strait Islander people? Are the gaps due to geographical, demographic and/or other factors?
- To what extent are PHC organisations funded through the IAHP and the health system servicing Aboriginal and Torres Strait Islander people in different contexts including hard to reach groups rather than just the more accessible populations?
- Which cohorts do we know least about?

Population

- What do Aboriginal and Torres Strait Islander people value in terms of service delivery and design?
- How do Aboriginal and Torres Strait Islander people experience the health system?
- Who is accessing PHC services and who is missing out?
- Where is there unmet need?
- What is working well, for whom and in what contexts and conditions? Why?
- To what extent are communities enabled to input to the design of local health service delivery?
- To what extent are individual people enabled to manage their own health?

Leadership and governance

- What are the implications of who is missing out on services and unmet need for the IAHP and the Implementation Plan in terms of policy, investment and practice?
- How well are governance and management processes across the system enabling implementation of the IAHP?
- What are the barriers?

Resourcing

- How is the investment in Indigenous PHC being implemented at the different levels of the system?
- What does it look like in practice?
- How well is knowledge and information used across the IAHP to inform and improve practice?

KEQ2: What difference is the IAHP making to the PHC system?

KEQ3: What difference is the IAHP making towards improving health and wellbeing for Aboriginal and Torres Strait Islander people?

KEQ2 and KEQ3 share sub-questions.

Service delivery

- To what extent does the IAHP support people to confidently access and navigate the PHC system?

Population

- How well is the IAHP meeting Indigenous peoples' holistic view of health, including their social and emotional wellbeing, and the social and cultural determinants of health?
- Are the IAHP initiatives changing peoples' lives for the better in terms of health and wellbeing outcomes?
- How is this changing over time?
- How is the investment in comprehensive PHC and targeted investment (in areas such as child and maternal health, eye, ear and oral health, smoking, chronic disease, mental health, alcohol and other drugs) making a difference in terms of outcomes?

Leadership and governance

- What are the interactions (system dynamics), including the barriers and enablers, between elements of the IAHP, other programs (including Commonwealth and State/Territory government funded) and the PHC system (e.g. PHNs)?

Resourcing

- Are the funded IAHP initiatives durable? Are they the right fit?
- Are they supplementing other PHC service delivery well?
- To what extent is the evaluation co-design and methodological approaches achieving the aims of the evaluation?

KEQ4: How can faster progress be made towards improving health and wellbeing for Aboriginal and Torres Strait Islander people?

Service delivery

- How can the reach of PHC be extended to cover hard-to-reach groups (due to geography and/or population factors)?
- What is working well?
- How can successes be shared more broadly with IAHP funded services and across the PHC system to celebrate and support learning?

Leadership and governance

- What needs to change at different levels of the health system?
- How can greater progress be made to achieve PHC system reform? What effective action can be taken to address the social and cultural determinants of health and environmental health?
- What needs to change in the IAHP, the Implementation plan and in the broader policy settings and processes?
- Is the mix of initiatives under the IAHP right in terms of maximising the levers for health system improvements in health and wellbeing outcomes?
- What needs to change in other policy areas (e.g. education, employment, social security, housing, food)?
- How can knowledge and information best be used across the IAHP to inform and improve practice?

Resourcing

- How could IAHP funding and grant-making processes be improved?

Appendix 7: IAHP evaluations and broader initiatives

The following two tables briefly describe the IAHP evaluation programme of work and related broader initiatives as at March 2018.

Programme name[1]	Summary	Completion date
Indigenous Australians' Health Programme	Allen + Clarke have been engaged to undertake the Evaluation of the Effectiveness of Primary Health Care for Aboriginal and Torres Strait Islander Australians. A Health Sector Evaluation Co-Design Group has been established to bring together people with a wide range of experiences and perspectives who are working across the health system. The group met for the first time on 20 December 2017 and for the second on 12 and 13 April 2018. Next steps include engaging with stakeholders as part of the evaluation co-design process. This evaluation will be undertaken in two phases: Phase 1 (the evaluation design) commenced in late 2017 and is expected to be completed in mid-2018; Phase 2 (the evaluation implementation) is anticipated to commence from September 2018 and be implemented over a four-year period.	Mid-2018 (Phase One)
	Deakin University completed Phase One of an Economic Evaluation of the Indigenous Australians' Health Programme (IAHP) in 2017–18. Phase One focused on the relative costs of an Indigenous specific compared to a non-Indigenous specific primary health care service; and the return on investment of the IAHP as measured by potentially preventable hospitalisations. Key findings were that: • The cost of providing primary health care through an ACCHS is higher than an episode of care at a private General Practice due to a more comprehensive and integrated approach to care, which is associated with better attendance, adherence to treatment and outcomes. • An increase in episodes of care in Indigenous specific primary health care services was associated with a slower rate of increase in potential preventable hospitalisations, but the effect was weak. The Department is currently scoping the next steps of the Economic Evaluation to explore the cost effectiveness and return on investment more broadly.	Mid-2018 (Phase One)

[1] This Appendix uses 'programme' instead of 'program'. The document was created by the Department of Health, which aligned the spelling of individual IAHP programs with the official title of IAHP that uses 'programme'.

Programme name[1]	Summary	Completion date
Integrated Team Care	A review was conducted of care coordination as part of Integrated Team Care and the impact it has on the health outcomes of Aboriginal and Torres Strait Islander people who are receiving services under the program. Overall, the review found that Integrated Team Care was having a positive impact on health outcomes and quality of life for Aboriginal and Torres Strait Islander people, providing better access to services and increasing their ability to navigate the health system. Additionally, the review found improved compliance in relation to health plans, self-management and medications.	October 2017
Australian Nurse Family Partnership Programme	There is currently a review planned with PM&C.	Mid-2021
	A previous evaluation report is publicly available and can be found at: https://www.anfpp.com.au/proven-results/publications/11-stage-1-evaluation-anfpp-final-report/file	2012
Integrated Early Childhood	An evaluation is currently underway and will consider the factors that contribute to the success of this program and which communities obtain the greatest benefit. The evaluation will measure education and health outcomes and will utilise site responses, case studies and an advisory group.	Mid-2019
Healthy Ears	These evaluations have been completed as part of an external evaluation examining the Australian Government's Indigenous Ear and Hearing Health Initiatives.	June 2017
Care for Kids Campaign		
Indigenous Ear Health		
Tackling Indigenous Smoking	A preliminary evaluation of this program has been conducted and is available at health.gov.au/internet/main/publishing.nsf/Content/indigenous-tis-target. A final evaluation is currently in progress.	Mid-2018
Indigenous Remote Service Delivery Traineeship Northern Territory Programme	This evaluation is being undertaken to consider if the program is effective in addressing identified needs, whether it provides value for money, if its structure and delivery can be strengthened, and whether performance and reporting arrangements can be improved.	Mid-2018
Remote Area Health Corps	Evaluation planning is currently underway. The Remote Area Health Corps program provides short-term placements (3–12 weeks) to remote health clinics in the Northern Territory for urban health professionals including general practitioners, registered nurses, and ear health and oral health professionals.	TBD
Health Care Homes Programme	This evaluation commenced in October 2017 with the aim of evaluating the effect of the Health Care Homes Stage One roll-out on practice experience and behaviour, quality of patient care, patient	December 2019

Programme name[1]	Summary	Completion date
	experience of care, service use and the cost of care for government, providers and patients. ACCHSs are participating in Stage One of Health Care Homes. This evaluation will also assess the programme's suitability for a national roll-out in the future.	
Australian National Audit Office – Audit: Primary health care services under the Indigenous Australians' Health Programme	The audit objective is to assess the effectiveness of the Department of Health's design, implementation and administration of primary health care under the Indigenous Australians' Health Programme (IAHP). Audit criteria include: - Did the Department of Health design the Indigenous Australians' Health Programme primary health care components consistent with the Government's objectives in establishing the IAHP? - Has the implementation of the IAHP primary healthcare components been supported through effective coordination with key government and non-government stakeholders? - Has the DOH's approach to assessing primary health care funding applications and negotiating funding agreements been consistent with the Commonwealth Grant Rules and Guidelines? - Has the DOH implemented a performance framework that supports effective management of individual PHC grants and enables ongoing assessment of program performance and progress towards outcomes?	Mid-2018

Broader Initiatives	
Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023	The Implementation plan was launched in October 2015 and outlines the actions to be taken by the Australian Government, the Aboriginal Community Controlled Health Sector, and other key stakeholders to give effect to the vision, principles, priorities and strategies of the National Aboriginal and Torres Strait Islander Health Plan 2013–2023. The next iteration of the Implementation plan for 2018–2023 will include content to address the social determinants and cultural determinants of Indigenous health and will include state and territory contributions. DOH will be discussing this development with the Implementation Plan Advisory Group in mid-2018 and engaging with a number of stakeholders including the National Aboriginal and Torres Strait Islander Health Standing Committee and the Health Partnership Forums throughout 2018. The *My Life My Lead – Opportunities for Strengthening Approaches to the Social Determinants and Cultural Determinants of Indigenous Health: Report on the National Consultations December 2017*

Programme name[1]	Summary	Completion date
	(http://www.health.gov.au/internet/main/publishing.nsf/Content/indigenous-ipag-consulation) will help inform the 2018–2023 Implementation plan and also inform the Closing the Gap – Refresh deliberations.	
Closing the Gap – Refresh (Whole of Government)	2018 marks the 10th anniversary of the Closing the Gap Framework. In response to the Prime Minister's 2018 Closing the Gap annual report, the Australian Governments is proposing to: 1. Discuss the principles of the refresh and priority areas; 2. Work together to propose target areas; and 3. Reach an agreement on the final targets and the actions governments will prioritise. A range of Indigenous and non-Indigenous communities, individuals and stakeholders at national, state and local levels are being consulted as part of the Closing the Gap – Refresh campaign. Following these important conversations, COAG has agreed to work together, in partnership with Aboriginal and Torres Strait Islander Peoples, to refresh the Closing the Gap agenda. Consultations with the health sector began in February 2018 and will continue to late-March 2018 across Australia. A list of these consultations can be found at https://closingthegaprefresh.pmc.gov.au/news/closing-gap-refresh-consultation-dates. The My Life My Lead report will also help inform Closing the Gap deliberations. In relation to the determination of final targets or commitments, this may build on the existing targets or result in the establishment of a new framework. It will include consideration of what evidence is required to demonstrate what works. The aim is to provide useful data for communities and organisations to guide and track progress into the future.	

Appendix 8: Ethics application process

During the preparation of the Monitoring and Evaluation Design Report, the evaluation team held preliminary discussions with the DOH Human Research Ethics Committee (HREC) secretariat. We were informed that the HREC was under review with a decision pending in May 2018. Given the pending decision, the team outlined a process for seeking ethics approval via the DOH HREC in the draft design report submitted 18 May 2018.

We were subsequently informed the Committee is to be disbanded at the end of August 2018. The Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) Research Ethics Committee was suggested as an appropriate alternative. The AIATSIS Research Ethics Committee is primarily responsible for reviewing all AIATSIS research projects and welcomes applications from external organisations. A fee is applicable for external applications.

The evaluation team will hold preliminary discussions with the AIATSIS Research Ethics Committee immediately approval is received to commence Phase 2 to confirm that it is the most appropriate committee to seek approval through.

Given the national scope of the evaluation, the team is keen to seek approval from an ethics body that will be recognised by other jurisdictional bodies. The DOH HREC Secretariat has suggested that a number of jurisdictional ethics committees may be happy to defer to the AIATSIS Committee. As such, we will seek guidance from AIATSIS and peak Aboriginal and Torres Strait Islander health peak bodies of the most appropriate jurisdictional level ethics committees (recognising that the evaluation involves engagement with Aboriginal Community Controlled Health Services (ACCHSs), state/territory managed health services, and private general practices, Primary Health networks, etc.). We will make contact and negotiate with these jurisdictional level committees to ascertain which committees are happy to defer to the AIATSIS Committee and which we will need to seek separate approval through. In this contact, we will share information on the evaluation design and emphasise the co-design process over Phase 1 and Phase 2.

During the negotiation and confirmation of the location of the site studies in Year 1 of Phase 2, we will undertake a similar exercise with regards to the authority of any local ethics committees (i.e. see which are happy to defer to AIATSIS or a jurisdictional committee, and which we will need to seek separate approval through).

The AIATSIS Research Ethics Committee is an HREC registered with the NHMRC. This means the AIATSIS Research Ethics Committee is required to comply with the *National Statement on Ethical Conduct in Human Research 2007* (National Statement) and any subsequent revisions. The table at the end of this Appendix outlines how the evaluation design addresses the relevant requirements of the National Statement, along with other steps we will take to seek ethics approval.

The AIATSIS Research Ethics Committee holds six meetings per year. Notification of the Committee's decision is provided within 10 working days after each meeting. Based on the 2018 schedule, meetings are likely to be held in February, April, June, August, October and December. Given the developmental nature of the evaluation, the frequency of the meetings provides regular opportunities for initial approval and subsequent amendments as required over the four years of the evaluation.

We anticipate our application process will be staged as follows:

- December 2018 – The first application will seek approval of the overall design, including the generic site study design and use of data. It may be that an ethics application

specifically focused on data will be required in the first half of 2019, following further data investigations and the establishment of the sites.

- June 2019 – We will seek an amendment covering the approval of all materials for Years 2 and 3 of the evaluation which start on 1 September in 2019 and 2020 (e.g. discussion outlines/question lists for all interviews and focus groups, consent forms, participant information about the evaluation, etc.).
- Subsequent amendments will be sought if the tools vary between Years 2 and 3, and for Year 4 tools.
- Subsequent amendments will also be sought for any additional data analyses required for sites or collaboratives.

Given the iterative, non-fixed nature of the evaluation design, we will do the following to facilitate the initial ethics approval process:

- *Supply information on the evaluation design to the Committee prior to the formal application* to establish any concerns or questions that need to be addressed in the formal application. The evaluation team will supply further information on the design as a supplementary paper if needed.
- *Confirm the governance processes for the evaluation.* The HSCG will be in place prior to the first application in November 2018, and most of the local governance processes for the amendment in June 2019. The CCG will be in place for any subsequent amendments.
- *Explicitly identify the components that will not be amendable to change* (e.g., particular data collection and aggregation to the national level for data analysis and comparability), and those that will be co-designed and/or require flexibility across different settings (e.g. at different sites, taking into account local preferences and needs and contexts). We will outline the process for how ethical principles and concerns will be addressed for those components that are amendable to change.
- *Demonstrate how we have received advice* via the Phase 1 co-design process, showing that the evaluation is informed by people who have networks with and knowledge of research and/or familiarity with Aboriginal and Torres Strait Islander culture and practices. We will seek supporting letters from the co-chairs of the HSCG, the chair of IPAG, and the CEO of NACCHO.
- Demonstrate how the evaluation design addresses the 14 principles outlined in the AIATSIS Guidelines for Ethical Research in Australian Indigenous Studies. These currently inform the evaluation's guiding principles (refer Appendix 1: Guiding ethical principles and evaluation standards).

In the subsequent amendment sought in June 2019, we will:

- *Demonstrate how we have received advice* via the Phase 2 co-design process from people familiar with the local Aboriginal and Torres Strait Islander culture and practices of those who will be participating in the evaluation.
- *Provide supporting letters* from the site-based evaluation governance groups and the CEOs of state/territory sector support agencies/peak bodies for ACCHSs.
- *Ensure all participant information* is conveyed in plain English that is easily understood by a young adult.

We have also identified the specific requirements from Chapter 4 of the *National Statement on Ethical Conduct in Human Research,* which we will be required to address. The following table briefly notes how the evaluation design currently addresses these requirements and other steps we will take.

Area	Requirements	Currently addressed by the evaluation design in the following ways
Research merit and integrity	4.7.1 The researcher should ensure that research methods are respectful and acknowledge the cultural distinctiveness of discrete Aboriginal and Torres Strait Islander communities or groups participating in the research – including national or multi-centre research.	Local governance Co-designed, tailored site evaluation plans Site-based researchers
	4.7.2 There should be evidence of support for the research project from relevant Aboriginal and Torres Strait Islander communities or groups and the research methodology should engage with their social and cultural practices.	Letters of support will be sought Co-designed tailored site evaluation plans
	4.7.3 The researcher should ensure that research methods provide for mutually agreed mechanisms for such matters as: a. appropriate recruitment techniques; b. suitable information about the research; c. notification of participants' consent and of research progress; and d. final reporting.	Co-designed, negotiated processes MOUs agreed with all sites
	4.7.4 The researcher should seek to identify any potential negative consequences of the proposed research, to design processes to monitor them, and to advise steps for minimising them.	Addressed in part by Section 7 – Limitations and Risks, and Appendix 10: Project risks and mitigation strategies.
Justice	4.7.5 The research methods and processes should provide opportunities to develop trust and a sense of equal research partnerships. 4.7.6 Where: a. the geographic location of the research is such that a significant number of the	The way in which 4.7.5 and 4.7.6 are addressed is articulated Appendix 1: Guiding ethical principles and evaluation standards

Area	Requirements	Currently addressed by the evaluation design in the following ways
	population are likely to be Aboriginal and Torres Strait Islander; and/or b. the research is focused on a topic or disease/health burden identified as being of specific concern to Aboriginal and Torres Strait Islander peoples and the population base has a significant proportion of Aboriginal and Torres Strait Islander people, the research should provide fair opportunity for involvement of Aboriginal and Torres Strait Islander people, and the guidelines in this chapter apply to those participants.	
Beneficence	4.7.7 The benefits from research should include the enhancement or establishment of capabilities, opportunities or research outcomes that advance the interests of Aboriginal and Torres Strait Islander people.	The way in which 4.7.7 is addressed is articulated in Appendix 1: Guiding ethical principles and evaluation standards
	4.7.8 The described benefits from research should have been discussed with and agreed to by the Aboriginal or Torres Strait Islander research stakeholders. 4.7.9 The realisable benefits for Aboriginal and Torres Strait Islander participants from the research processes, outcomes and outputs should be distributed in a way that is agreed to and considered fair by these participants.	4.7.8 and 4.7.9 will occur as part of the site negotiations
Respect	4.7.10 The research proposal should demonstrate evidence of respectful engagement with Aboriginal and Torres Strait Islander people. Depending on the circumstances, this might require letters of support from Aboriginal and/or Torres Strait Islander community Councils or other organisations accepted by the participating communities (see Chapter 2.1: Risk and benefit and Chapter 2.2: General requirements for consent, especially paragraph 2.2.13). The	Letters will be sought The ways in which 4.7.10 and 4.7.11 are addressed is described in Appendix 1: Guiding ethical principles and evaluation standards

Area	Requirements	Currently addressed by the evaluation design in the following ways
	research processes should foster respectful, ethical research relationships that affirm the right of people to have different values, norms and aspirations. 4.7.11 The research approach should value and create opportunities to draw on the knowledge and wisdom of Aboriginal and Torres Strait Islander people by their active engagement in the research processes, including the interpretation of the research data.	
	4.7.12 National or multi-centre researchers should take care to gain local level support for research methods that risk not respecting cultural and language protocols.	Any such methods will be identified in discussion with the sites

Appendix 9: Evaluation implementation plan

The following outlines a provisional implementation plan for the evaluation based on a start date of 1 September 2018. The implementation plan will be finalised as part of the contracting process for Phase 2 of the evaluation.

The following tables provide a breakdown of the key activities that will occur over each of the four years:

- Year 1: Co-design establishment, September 2018 – July 2019 (Year 1 is 11 months in order to undertake the first round of site visits in Years 2–4 pre-Christmas and before the wet season in northern parts of Australia)
- Year 2: Co-creation of knowledge and action, August 2019 – July 2020
- Year 3: Co-creation of knowledge and action, August 2020 – July 2021
- Year 4: Evaluation transition and final report, August 2021 – July 2022.

Appendix 11: Communication strategy outlines the schedule of communications that will occur.

Year 1 – Co-design establishment

Time	Evaluation management	Data	Site-based studies	National and state/territory engagement	Deliverables
September – October 2018	**Planning** Project initiation, planning, team establishment and meeting **Ethics** Ethics preparation for 4 December 2018 application (due 19 November)	**Planning** Initial work on quant and qual workplan, including specification of what is needed to address each evaluation question (e.g. source, method, criteria for making judgements)	**Planning site visits 1.1** Developing site establishment protocols and fieldwork tools **Site selection** Set-up (September) and attend Health Partnership Forum meetings where	**Planning** Developing engagement protocols and tools **Co-design** HSCG Meeting (11–12 October)	HSCG meeting summary

Time	Evaluation management	Data	Site-based studies	National and state/territory engagement	Deliverables
		Quantitative data workplan and engagement with DOH initiated re feasibility and accessibility	possible or meet with members (October – November) to present proposed approach and discuss site selection		
November – December 2018	**Ethics** Ethics application – 19 November for 4 December meeting	**Planning** Above continued	**Site selection** Continued **Piloting** Site establishment protocols and fieldwork tools (November) **Set up site visits** (November)	**Re-engagement** With national and state/territory stakeholders (November)	Ethics application
January – February 2019		**Planning** Above continued	**Set up site visits** Continued late January – February **Site visits 1.1** *Invitation, engagement and relationship-building visit* (February)	**Re-engagement** Continued late January – February	

Time	Evaluation management	Data	Site-based studies	National and state/territory engagement	Deliverables
			Visiting and meeting people, presentations, key informant interviews, group discussions Post-visit analysis and summary		
March – April 2019	**Reflection and planning** Evaluation team reflects on process learnings and other information gathered to date in relation to evaluation questions (March) Plan focus for next 6 months (March)		**Site visits 1.1 continued** **Planning, piloting and setting up site visits 1.2** Preparation for 2nd site visits, including developing and piloting protocols and tools, and setting up visits (February – March) **Year 2 planning** Developing fieldwork and co-creation tools for Year 2 (March – April) and June ethics application	MOUs and national and state/territory specific evaluation plans **Co-design** HSCG Meeting (April)	**March – Site selection report** HSCG meeting summary
May – June 2019	**Ethics**	**Baseline data** Trial baseline data run and analysis for	**Site visit 1.2**	Fieldwork with national and state/territory stakeholders	Tailored site evaluation plans, service maps and descriptions

Time	Evaluation management	Data	Site-based studies	National and state/territory engagement	Deliverables
	Amendment sought for additional data and fieldwork (June)	confirmed site boundaries (June)	*Confirmation, planning and mapping visit* Confirmation of participation, signing MOU, determining data boundaries, mapping IAHP, PHC and health service provision, detailed contextual description, commence co-designing site evaluation plan State/territory engagement Post-visit analysis and write-up of tailored site evaluation plans and service provision maps		
July 2019	**Reflection and planning** Evaluation team reflects on process learnings, baseline and other information gathered to date in relation to evaluation questions (July)	**Baseline data** Provision of data by DOH to evaluation team for August – September visits (June) Baseline data analysis and preparation for site	**Site visits 1.2 continued** **Planning, piloting and setting up site visits Year 2.1**		Tailored site evaluation plans, service maps and descriptions Further data tools, indicators and baseline data

Time	Evaluation management	Data	Site-based studies	National and state/territory engagement	Deliverables
	Plan focus for next 6 months (July) **Annual interim report** Start drafting, including process learnings, evaluation learnings and implications for Year 2 (July)	presentations over August – September 2019 (June – July)			

Year 2 – Co-creation of knowledge and action

Time	Evaluation management	Data	Sites and state/territory	Collaboratives and national engagement	Deliverables
August – September 2019	**Annual interim report** Draft report (August) Finalise report (September)	**Baseline data continued** Provision of data by DOH to evaluation team for October – November 2019 visits (August) Baseline data analysis and preparation for site presentations over	**Site visits 2.1** *Fieldwork and co-creation visits* Fieldwork – Key informant interviews, in-depth interviews, focus groups, collection of clinical indicator data	Preliminary discussion of draft annual interim report with DOH and other national stakeholders (September) **Co-design meetings** HSCG meeting (September)	Draft annual interim report 1 Site data reports HSCG and CCG meeting summaries

Time	Evaluation management	Data	Sites and state/territory	Collaboratives and national engagement	Deliverables
		October – November (August – September)	Co-creation sessions will include discussion of baseline data, site evaluation plan and service provision map, current issues, solutions and actions. It will also include discussion of draft interim report State/territory engagement as part of site visits Post-visit analysis and summary	1st CCG meeting (September) **Collaboratives** Identification of emerging themes and initiate collaboratives (September)	
October – November 2019			**Site visits 2.1 continued**	**Collaboratives** First set of collaborative sessions held Collaborative summaries	**October – Final annual interim report 1** Site data reports
December 2019 – January 2020	**Reflection and planning** Evaluation team reflect on information gathered to date on evaluation questions (December)		**Planning and setting up site visits 2.2** **Year 3 planning**		

Time	Evaluation management	Data	Sites and state/territory	Collaboratives and national engagement	Deliverables
	Plan focus for next 6 months (December)				
February – March 2020	**Progress report** Prepare progress report (February)		**Site visits 2.2** *Fieldwork and co-creation visits* State/territory engagement as part of site visits Post-visit analysis and summary	Fieldwork with national and state/territory stakeholders Discussion of progress report with DOH **Co-design meetings** HSCG meeting (March) CCG meeting (March) **Collaboratives** Check emerging themes and initiate any further collaboratives (March)	**March – Progress report**
April – May 2020	**Ethics** Preparation for any ethics amendments for Year 3 if any changes		**Site visits 2.2 continued**	**Collaboratives** Collaborative sessions held Collaborative summaries	
June – July 2020	**Reflection and planning** Evaluation team reflects on information gathered to	**Annual update** Provision of data by DOH to evaluation team for	**Planning and setting up site visits 3.1**		Site data reports

Time	Evaluation management	Data	Sites and state/territory	Collaboratives and national engagement	Deliverables
	date on evaluation questions (June) Plan focus for next 6 months (June) **Annual interim report** Start drafting **Ethics** Ethics amendments for Year 3 if any changes (June)	August – September 2020 visits (June) Data analysis and preparation for site presentations over August – September 2020 (June – July)			

Year 3 – Co-creation of knowledge and action

Time	Evaluation management	Data	Sites and state/territory	Collaboratives and national engagement	Deliverables
August – September 2020	**Annual interim report** Draft report (August) Finalise report (September)	**Annual update continued** Provision of data by DOH to evaluation team for October – November 2019 visits (August) Baseline data analysis and preparation for site presentations over	**Site visits 3.1** *Fieldwork and co-creation visits* Fieldwork – Key informant interviews, in-depth interviews, focus groups,	Preliminary discussion of draft annual interim report with DOH and other national stakeholders (September) **Co-design meetings** HSCG meeting (September)	Draft annual interim report 2 Site data reports HSCG and CCG meeting summaries

Time	Evaluation management	Data	Sites and state/territory	Collaboratives and national engagement	Deliverables
		October – November (August – September)	collection of clinical indicator data Co-creation sessions will include discussion of baseline data, site evaluation plan and service provision map, current issues, solutions and actions. It will also include discussion of draft interim report State/territory engagement as part of site visits Post-visit analysis and summary	CCG meeting (September) **Collaboratives** Identification of emerging themes and initiate collaboratives (September)	
October – November 2020			**Site visits 3.1 continued**	**Collaboratives** Collaborative sessions held Collaborative summaries	**October – Final annual interim report 2** Site data reports
December 2020 – January 2021	**Reflection and planning** Evaluation team reflect on information gathered to		**Planning and setting up site visits 3.2** **Year 4 planning**		

Time	Evaluation management	Data	Sites and state/territory	Collaboratives and national engagement	Deliverables
	date on evaluation questions (December) Plan focus for next 6 months (December)				
February – March 2021	**Progress report** Prepare progress report (February)		**Site visits 3.2** *Fieldwork and co-creation visits* Visit 3.2 will also include reflections on the value of the evaluation and planning for how to transition and sustain the valued aspects of the monitoring and evaluation process State/territory engagement as part of site visits Post-visit analysis and summary	Fieldwork with national and state/territory stakeholders Discussion of progress report with DOH **Co-design meetings** HSCG meeting (March) CCG meeting (March) **Collaboratives** Check emerging themes and initiate any further collaboratives (March)	**March – Progress report**
April – May 2021	**Ethics**		**Site visits 3.2 continued**	**Collaboratives** Collaborative sessions held	

Time	Evaluation management	Data	Sites and state/territory	Collaboratives and national engagement	Deliverables
	Preparation of ethics applications for Year 4 if any changes			Collaborative summaries	
June – July 2021	**Reflection and planning** Evaluation team reflects on information gathered to date on evaluation questions (June) Plan focus for next 6 months (June) **Annual interim report** Start drafting **Ethics** Ethics amendments for Year 4 if any changes (June)	**Annual update** Provision of data by DOH to evaluation team for August – September 2021 visits (June) Data analysis and preparation for site presentations over August – September 2021 (June – July)	**Planning and setting up site visits 4.1** Piloting any changes to tools for visit 4.1 **Further Year 4 planning**		Site data reports

Year 4 – Evaluation transition and final report

Time	Evaluation management	Data	Sites and state/territory engagement	Collaboratives and national engagement	Deliverables
August - September 2021		**Annual update continued** Provision of data by DOH to evaluation team for October – November visits (August) Data analysis and preparation for site presentations over October – November (August – September)	**Site visits 4.1** *FINAL fieldwork and co-creation session* Co-creation sessions will include discussion of updated data, emerging issues and findings (draft interim report 3), solutions and actions Sessions will also conclude reflections on the value of the evaluation and discussions about how to transition and sustain the valued aspects of the monitoring and evaluation process State/territory engagement as part of site visits Post-visit analysis and summaries	Preliminary discussion of draft annual interim report with DOH and other national stakeholders (September) **Co-design meetings** HSCG meeting (September) CCG meeting (September) **Collaboratives** Identification of emerging themes and initiate collaboratives (September)	Draft annual interim report 3 Site data reports HSCG and CCG meeting summaries

Time	Evaluation management	Data	Sites and state/territory engagement	Collaboratives and national engagement	Deliverables
October – November 2021			**Site visits 4.1 continued**	**Collaboratives** Collaborative sessions held Collaborative summaries	**October – Final annual interim report 3** Site data reports
December 2021 – January 2022	**Reflection and planning** Evaluation team reflects on information gathered to date on evaluation questions (December) Plan focus for the last 6 months and the final report (December) **Draft final report** Commence planning and drafting				
February – March 2022	**Draft final report** Ongoing drafting			Fieldwork with national and state/territory stakeholders Discussion of draft report with DOH **Co-design meetings**	**March – Draft report** HSCG and CCG summaries

Time	Evaluation management	Data	Sites and state/territory engagement	Collaboratives and national engagement	Deliverables
				HSCG meeting (March) CCG meeting (March)	
April – May 2022	**Draft final report** Incorporating feedback from March meetings		**Final site visits and state/territory engagement** Visiting all sites and engaging with other stakeholders to discuss draft report	**Collaboratives, national and other stakeholders** Discussing draft report with collaboratives	
June – July 2022	**Final report** Incorporating feedback from April-May meetings and finalising report Review of report				**July – Final report**

Appendix 10: Project risks and mitigation strategies

This appendix describes the range of risks, their potential impact and mitigation strategies.

Activity/ deliverable	Risk description and cause/s of risk	Impact	Likelihood	Risk level	Risk level acceptable?	Mitigation
Ethics approval	**Risk description** Not receiving ethics approval in time to begin evaluation in anticipated timeframe **Cause/s of risk** The complexity of ethics approval processes for multi-site evaluation involving all states/territories	High	Medium	Medium	Yes	Ensure sufficient resources are devoted to a high-quality, ethical design, and all related documents are produced within the timeframes Communicate with the ethics committee secretariats ahead of time to ensure the requirements are clear, and that the application is booked in and anticipated Negotiate a streamlined, national process
Pressure on timeframes and resources to complete the evaluation	**Risk description** There is a delay in starting the evaluation and/or timeframes for different phases are not met **Cause/s of risk** There is insufficient resource to implement the evaluation as planned	High	Medium	Medium	Yes	The evaluation will include a realistic establishment phase The number of sites and cycles could be renegotiated if delays affect the feasibility of the proposed design Additional evaluation team resources may be identified and deployed at critical times during the evaluation Support from the HSCG and other co-design participants in rethinking aspects of the evaluation

Activity/ deliverable	Risk description and cause/s of risk	Impact	Likelihood	Risk level	Risk level acceptable?	Mitigation
	Delays in approval of the evaluation design, provider and budget Processes for engagement, data collection and access to datasets take longer than anticipated Negotiation of agreements at sites and with clusters takes longer than anticipated Unanticipated events, such as changes in personnel and in priorities of key stakeholders Unpredictable factors, such as funerals, cultural business, and road closures due to seasonal flooding					
Data quality and completeness	**Risk description** The extent to which Aboriginal and Torres Strait Islander people are correctly identified and 'counted' in the various health-related data collections	Low	High	Low	Yes	Under-counting of Indigenous people is an ongoing issue that is slowly being addressed, but there is unlikely to be any significant shifts affecting the validity of results over the relatively short period of the evaluation Discussion at sites about the data and interpretation of initial and subsequent data

Activity/ deliverable	Risk description and cause/s of risk	Impact	Likelihood	Risk level	Risk level acceptable?	Mitigation
	Mismatch between data collected at sites and that held by the DOH **Cause/s of risk** Under-counting and variation in the effectiveness of processes in PHC to identify patients and correctly document Aboriginal and/or Torres Strait Islander descent Reluctance of some Indigenous people to self-identify and/or to use PHC services					Supplementing quantitative analysis with qualitative findings Identification through sites and networks re who is 'missing' from the data and strategies to address this
Access to national data collections	**Risk description** Access to the necessary data is delayed, and/or the data is incomplete or does not meet specifications **Cause/s of risk** Barriers to or delays in gaining necessary access Less commonly accessed data (e.g. reporting against contracts) has not been assessed for	High	Low (existing data)	Low (existing data)	Yes	Some data sources are routinely collected and have been accessed regularly for other evaluations (e.g. Sentinel Sites Evaluation) The existing data collections have been in place and used for reporting purposes for a significant period, so it is highly likely that data issues, such as incompleteness or internal validity, have been addressed

Activity/ deliverable	Risk description and cause/s of risk	Impact	Likelihood	Risk level	Risk level acceptable?	Mitigation
	internal or reporting validity issues					
Variation in capacity and capability of PHC service providers	Risk description The evaluation accelerates progress in high performing PHC services and widens the gap between services **Cause/s of risk** Well-organised and/or better resourced PHC services may be able to make more effective use of opportunities and resources available through the evaluation than less well-organised or resourced services The evaluation team has limited resources and capacity to support engagement with services that are less organised or resourced	Medium	Medium	Low	Yes	Utilise a variety of means to build capacity where it is most likely to make a difference, and to gain a more complete understanding of factors affecting progress on CtG and improved patient experience and outcomes A flexible budget and other mechanisms to build capability and help resource participation by less well-organised/resourced PHC services
Continuity and availability of key members of the evaluation team	**Risk description** Loss of critical expertise and leadership in the evaluation team	Medium	Low	Medium	Yes	Maintaining engagement across the evaluation team, so that there is a shared understanding and collective approach to implementation

Activity/ deliverable	Risk description and cause/s of risk	Impact	Likelihood	Risk level	Risk level acceptable?	Mitigation
	Cause/s of risk Unanticipated or competing demands Insufficient resources or support Delay in approval and establishment of the evaluation					Ensuring adequate support for the evaluation and incentive to prioritise its work Recruitment of additional team members once the evaluation is approved Ongoing engagement of the HSCG and other participants in the co-design to strengthen the wider 'team'
Balance between quantitative data and qualitative data **Capturing the intangible elements adequately**	**Risk description** That undue focus is given to quantitative findings **Cause/s of risk** Collecting and responding to quantitative data takes more resources or dominates the evaluation processes, so that qualitative data is given less attention Difficulty in capturing the 'intangible' aspects – including cultural dimensions and organisational features that affect access, performance and outcomes	Medium	Low	Low	Yes	Structuring the evaluation establishment and the implementation to ensure all aspects of the proposed evaluation are given sufficient emphasis and resources Ongoing engagement with co-design partners and participants Ensuring there are evaluation team members with strengths in qualitative methods

Activity/ deliverable	Risk description and cause/s of risk	Impact	Likelihood	Risk level	Risk level acceptable?	Mitigation
Acceptance of the evaluation findings and conclusions	**Risk description** Key stakeholders do not consider the interim and/or evaluation findings are valid or robust, or have different interpretations of the data **Cause/s of risk** Key stakeholders hold different views of what 'success' looks like, along with the type of evaluation and data they value Providers and communities may turn the lens on central processes or factors such as funding	Medium	Medium	Medium	Yes	The proposed evaluation design and process is highly participatory and transparent so that key stakeholders have an opportunity to contribute to how 'success' is defined, engage in workshops to 'make meaning' of the findings, and see how the findings have been interpreted and validated along with the process for arriving at the conclusions Develop different models of success to take account of the range of perspectives, and legitimate these via evidence from a range of sources (e.g. peer-reviewed literature, cultural practice) Negotiate with key stakeholders early in the implementation process about how best to incorporate findings regarding the policy and funding environment, if they arise Engage national-level participants in an iterative, reflective process as part of the evaluation
The evaluation process and conclusions	**Risk description** The evaluation itself is not culturally competent The evaluation process or conclusions contribute to further	High	Low	Medium	Yes	The cultural competency of the evaluation design, process and team, and mitigation strategies have been explicitly addressed in this proposal The evaluation team will be highly committed and motivated to ensure an ethical and

Activity/ deliverable	Risk description and cause/s of risk	Impact	Likelihood	Risk level	Risk level acceptable?	Mitigation
	harm for Aboriginal and/or Torres Strait Islander people					methodologically robust and sound evaluation is carried out The ethics approval process will help ensure the evaluation does not cause further harm, and actually provide benefit for Aboriginal and Torres Strait Islander people and their communities

Appendix 11: Communication strategy

This appendix outlines a schedule for rolling out the communications strategy and potential risks and mitigation strategies.

11.1. Communications schedule

Materials	Distribution channels	Content and key messages	Target audience	Potential interest/involvement	Timing
Media release to announce start of Phase 2 of the evaluation	Website, Aboriginal and Torres Strait Islander media, health sector media, mainstream media, social media, stakeholder channels	Major evaluation to examine existing PHC models and programs and drive improvements to help achieve CtG health targets	Aboriginal and Torres Strait Islander health sector, communities across Australia, mainstream health sector, Australian public, policymakers	Aboriginal and Torres Strait Islander health sector and media, also mainstream health sector Lower interest from mainstream media due to limited 'takeaways', i.e. no findings at this early stage	Mid-2018
HSCG communiqué	Website, stakeholder channels	Update on HSCG discussions, key points of action emerging from these discussions	HSCG partners and stakeholder groups	Limited – key resource for internal stakeholder communications	Six monthly
Update/newsletter	Website, social media, Aboriginal and Torres Strait Islander media, stakeholder channels	Latest news on evaluation activities with positive messaging on progress	HSCG partners and stakeholder groups, Aboriginal and Torres Strait Islander health sector, mainstream health sector, policymakers	News briefs stakeholder channels, Aboriginal and Torres Strait Islander media, mainstream health media	Six monthly

Materials	Distribution channels	Content and key messages	Target audience	Potential interest/involvement	Timing
Fact sheets on Phase 2 of the evaluation	Website, PDFs for email distribution, hard copies for communities, organisations and event handouts	Clear and concise description of evaluation activities and potential benefits	Aboriginal and Torres Strait Islander individuals, communities and organisations, mainstream media, event attendees, researchers, general public	Need to have well-packaged and presented information about all aspects of the Evaluation, accessible to all interested parties	Produce by end of 2018 Review and update regularly, and ensure ample hard copy supply
Ministerial briefing	Internal communications only	Review of evaluation progress and any issues	Minister and key ministerial staff, senior DOH, State policymakers	Ministerial and departmental staff kept abreast of evaluation progress and indicative findings if any	Yearly
Interim reports	On case-by-case basis, e.g. yearly report to DOH may have privacy concerns: website, social media, stakeholder channels, Aboriginal and Torres Strait Islander media, health sector media, mainstream media	Determined by nature of report	Determined by nature of report	Health sector in general – determined by nature of report	As reports come to hand
Evaluation-related research, videos, media	Social media, website	Re-broadcasting relevant third-party content and bespoke videos	Aboriginal and Torres Strait Islander health sector, communities and organisations, mainstream health sector, researchers, interested members of public	Links to video content can drive good engagement from social media users Links to reports, media, etc. present opportunities to drive website traffic	Continuous as relevant material comes to hand

Materials	Distribution channels	Content and key messages	Target audience	Potential interest/involvement	Timing
Conference/workshop presentations	Website, Aboriginal and Torres Strait Islander media, health sector media, social media, stakeholder channels, mainstream media as opportunities present	Progress of evaluation and its ultimate aims, i.e. to improve PHC system and thus help meet CtG targets	Aboriginal and Torres Strait Islander health sector, mainstream health sector, policymakers, researchers, interested members of public (via social media)	Conferences and events present opportunities for networking and engaging with media, either directly or via conference, event organiser	On an event-by-event basis
Aboriginal and Torres Strait Islander media appearances (e.g. radio, TV, print and online media)	Aboriginal and Torres Strait Islander media, social media, newsletter, stakeholder channels, website	Aboriginal and Torres Strait Islander people driving this major undertaking, findings to result in lasting system changes and deliver positive health outcomes	Aboriginal and Torres Strait Islander individuals, communities and organisations, Aboriginal and Torres Strait Islander health sector	Direct contact with key stakeholder groups, encouraging participation, engagement with process and interest in eventual outcomes	Continuous as opportunities present
Media release and formal event to mark end and success of Phase 2 of the evaluation	Website, Aboriginal and Torres Strait Islander media, health sector media, mainstream media, social media, stakeholder channels	Highlight key findings and how these will inform changes to PHC system to help meet CtG targets Successful outcome of Aboriginal and Torres Strait Islander-driven project	Australian public, Aboriginal and Torres Strait Islander health sector, organisations and communities, mainstream health sector, policymakers	Prime opportunity to inform wider Australian public of positive developments in Aboriginal and Torres Strait Islander health Celebrate involvement of Aboriginal and Torres Strait Islander people, communities and organisations in driving positive change	Mid-2022

Materials	Distribution channels	Content and key messages	Target audience	Potential interest/involvement	Timing
Fact sheets on findings and implications for Aboriginal and Torres Strait Islander PHC delivery	Produce to accompany media release, announcement event and other media activities Ongoing distribution via website, social media, email, printed copies for mail-outs, event handouts	Clear, concise messaging around evaluation findings and likely benefits, especially in terms of CtG	All media, Aboriginal and Torres Strait Islander health sector, communities, organisations and individuals, mainstream health sector, policymakers, researchers, interested members of the public	Legacy resources available as long-term reference for Aboriginal and Torres Strait Islander health sector, mainstream health sector, media, policymakers, researchers, students, Aboriginal and Torres Strait Islander communities and organisations, interested members of the public	Mid-2022 – prepare in advance of media release and related formal event

11.2. Communications risks and mitigations

Risk	Consequence	Likelihood	Risk rating	Mitigation
Legal issues e.g. adherence with privacy laws, content ownership, intellectual property infringement	Major	Rare	Very high	Prevention – we will only use content with permission and when we are confident it is correct
Getting messages wrong (facts)	Major	Rare	Very high	Prevention – peer review
Key audiences excluded	Major	Unlikely	Very high	Prevention – ensure communications are provided through a range of channels
Media indifference (due to four-year period with minimal news takeaways)	Medium	Likely	High	Adaptive – use multiple communications channels opportunistically to keep evaluation on media agenda
Approvals processes	Medium	Moderate	High	Prevention – planning communications in advance
Adverse commentary	Medium	Moderate	High	Prevention – moderation policy (social media) Reaction – key spokespeople and moderating comments
High evaluation team media visibility	Medium	Rare	Medium	Prevention – evaluation team to adopt low-key background media role and use partner spokespeople for all announcements
Getting messaging wrong (communication medium)	Minor	Rare	Low	Prevention – evaluation team to develop overarching guidelines around communications
Significant changes to COAG CtG health targets	Minor	Unlikely	Low	Adaptive – DOH would advise on adjusting Communications Strategy in this unlikely event

Likelihood	**Consequence**			
	Negligible	**Minor**	**Medium**	**Major**
Very likely	High	High	Very high	Very high
Likely	Medium	High	High	Very high
Moderate	Low	Medium	High	Very high
Unlikely	Low	Low	Medium	Very high
Rare	**Low**	**Low**	**Medium**	**Very high**

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