



# 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

26 July 2018

## Acknowledgements

**Acknowledgment of Country.** In the spirit of respect and reconciliation, the evaluation team acknowledge and pay respect to the Traditional Custodians of Australia – the Aboriginal and Torres Strait Islander people, and their continuing connection to land, waters, sea and community.

**Acknowledgement of Evaluation Co-design Partners.** The Indigenous Australians' Health Programme (IAHP) evaluation team would like to express our appreciation to the members of the Health Sector Co-design Group who worked alongside and robustly engaged with the IAHP evaluation team and the Department of Health on the design of the evaluation of the Australian Government's investment in Aboriginal and Torres Strait Islander Primary Health Care through the Indigenous Australians' Health Programme.

In the evaluation co-design phase, the members of the Health Sector Co-design Group were Ms Kate Thomann and Dr Mark Wenitong (who both co-chaired the group), Dr Dawn Casey, Ms Janine Mohamed, Mr Karl Briscoe, Ms Angela Young, Prof Norm Sheehan, Ms Jessica Yamaguchi, Ms Karen Visser, Dr Fadwa Al-Yaman, Ms Kim Grey, Dr Jeanette Ward and Ms Nicki Herriot.

**Acknowledgement of jurisdictional and community organisations.** The IAHP evaluation team would also like to thank people from the state/territory health organisations, the peak bodies and community members who also gave their time and ideas to ensure that the design of the evaluation would meet a wide range of needs.

**About the artist and artwork:** The artwork for this report and other IAHP evaluation documents was produced by Emma Walke. Emma is a Bundjalung Aboriginal woman from northern New South Wales (NSW) and is on the evaluation team. The following is her description of the artwork:

*Because I don't speak for every Country, and because we are working across many of them, the work seeks to represent Indigenous Australia. I feel that colour makes a statement so I have used colours that can be linked to many of our communities and Countries, land or sea based. The colours represent our people and the land they come from – ochres/yellows represent desert and hills and the cliffs where our ochres come from. Blues for ocean and blue greens for rivers.*

*The circles are universal in the way they represent groups or clans of people, the markings inside some of the circles represent individuals.*

*The dots and slashes are representational of tracks and time lines. There are a few blank circles – they represent the missing, the lost peoples.*

*I thought I would try and incorporate the colours to show respect for them.*

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**The evaluation team** who undertook the co-design project resulting in this Monitoring and Evaluation Design Report was led by *Allen + Clarke* and consisted of the following members and partner organisations:

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## Acronyms

ABS: Australian Bureau of Statistics

ACCHS: Aboriginal Community Controlled Health Service

AMS: Aboriginal Medical Service

AOD: alcohol and other drugs

ASGC-RA: Australian Standard Geographical Classification – Remoteness Areas

CCG: Community Co-design Group

COAG: Council of Australian Governments

CtG: Closing the Gap

DOH: Department of Health (Australian Government)

HREC: Human Research Ethics Committee

HSCG: Health Sector Co-design Group

IAHP: Indigenous Australians' Health Programme

KEQ: key evaluation questions

MBS: Medicare Benefits Schedule

MOU: Memorandum of Understanding

NACCHO: National Aboriginal Community Controlled Health Organisation

nKPI: national Key Performance Indicator

NSW: New South Wales

PBS: Pharmaceutical Benefits Scheme

PHC: primary health care

PHN: Primary Health Network

PIP: Practice Incentive Program

PIP-IHI: Practice Incentive Program-Indigenous Health Incentive

PM&C: Department of the Prime Minister and Cabinet (Australian Government)

VII: Voluntary Indigenous Identifier



## Glossary

**Aboriginal Community Controlled Health Services (ACCHSs)** are ‘primary health care services initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it (through a locally elected Board of Management).’<sup>1</sup>

**Aboriginal Medical Service** refers to state/territory-managed Aboriginal Medical Service (AMSs) and other non-community controlled health services that are designed primarily to meet the needs of Aboriginal and Torres Strait Islander people. While all ACCHSs are AMSs, the reverse is not the case.

**Health service** refers to any primary health care (PHC) service, including ACCHS, AMS, private general practice and government and non-government funded service.

**Aboriginal Community Controlled Health Organisations**, in this report, refer to state/territory affiliates of the peak body National Aboriginal Community Controlled Health Organisation (NACCHO).

**Co-design and co-creation** – For the purposes of this evaluation, co-design is defined as the active involvement of stakeholders at national, regional and local levels, whose perspectives will collectively inform and shape the ongoing iterations of the evaluation over the four years of its implementation. Co-creation is defined as the collective creation of knowledge and understanding, and solutions, responses and actions to address issues. Simply put, co-design in this evaluation is focused on implementation and co-creation is focused on addressing the findings emerging throughout the evaluation. Both co-design and co-creation are focused on developing innovative solutions through participatory, collaborative processes.

**Consumers** refer to people who use PHC and other health services. The evaluation uses the phrasing ‘people who use and do not use services’ to include everyone who uses or could potentially use PHC and other health services.

The term **Indigenous** is used to refer to Indigenous people internationally. When used by the *Indigenous Australians’ Health Programme* or in the Australian context, it should be read to be synonymous with the phrase ‘Aboriginal and Torres Strait Islander’.

**Investment** is used to encompass the comprehensive nature of the IAHP and the different parts of the system on which it is focused, e.g. service delivery, governance and leadership, information, workforce, funding.

**Site** refers to a geographically defined area that is the focus of ‘place-based’ evaluation activities.



## Evaluation-specific terms

The following definitions are direct quotes from the *Encyclopedia of Evaluation*,<sup>2</sup> unless noted or italicised text is used.

**Criteria** are the aspects, qualities, or dimensions that distinguish a more meritorious or valuable evaluand from one that is less meritorious or valuable constitute *criteria*. Criteria are central to any evaluation, whether they are determined at the beginning of the evaluation or emerge during the evaluation process. In most cases, it is possible, using a needs assessment and an analysis of other relevant values, to identify many criteria. However, the open-ended elements of an evaluation often uncover other criteria that should also be considered when drawing conclusions. Performance or attributes are evaluated on each criterion, and the results are then synthesised to draw evaluative conclusions.

**Developmental evaluation's** purpose is to help develop the intervention or program. ... Evaluators become involved in improving the intervention and use evaluative approaches to facilitate ongoing program, project, product, staff, and organisational development. The evaluator's primary function... is to facilitate and elucidate... discussions by infusing evaluative questions, data, and logic and to support data-based decision-making in the developmental process.

**Effectiveness** is the extent to which an evaluand (see next entry) produces desired or intended outcomes. Effectiveness alone provides a poor assessment of overall evaluand merit or worth: it is possible for something to be 'effective' (i.e. produce desirable intended outcomes) but at the same time produce serious detrimental, if unintended, effects. It is also possible for an evaluand to be highly effective but extremely inefficient or overly costly. Claims of effectiveness require the demonstration of a causal link between the evaluand and the desired changes to show that they are, in fact, outcomes caused by the evaluand and are not coincidental changes.

**Evaluand** is a generic term that may apply to any object of an evaluation. It may be a person, program, idea, policy, product, object, or any other entity being evaluated.

**Evaluation** is an applied inquiry process for collecting and synthesising evidence that culminates in conclusions about the state of affairs, value, merit, worth, significance, or quality of a program, product, person, policy, proposal, or plan. Conclusions made in evaluations encompass both an empirical aspect (that something is the case) and a normative aspect (judgement about the value of something). It is the value feature that distinguishes evaluation from other types of inquiry, such as basic science research, clinical epidemiology, investigative journalism, or public polling.

**Formative evaluation** is usually conducted during the development or delivery of a program or product with the intention of providing feedback to improve the evaluand.

**Outcomes**, in this report, refers to changes that have occurred as a result of, or have been contributed by, a program or initiative. Outcomes are changes, results and impacts that may be short or long term; proximal or distal; primary or secondary; intended or unintended; positive or negative; and singular, multiple or hierarchical. Evaluations, especially summative evaluations, measure outcomes at the individual level (changes in knowledge, skills, attitudes), organisational level (change in policies, practices, capacity), community level (changes in employment rates, school achievement, recycling), and the policy or government level (changes in laws, regulations,



sources of funding). *In this report, **changes** may be used in the place of outcomes, and if so, it means that the change has been caused or contributed to by a program or initiative.*

**Impact evaluation** is the assessment of whether an initiative makes a difference. This term has a range of meanings. Our usage is broad, covering positive and negative, primary and secondary effects that are produced by an initiative over the short-, medium- and long-term, either directly or indirectly, intended or unintended. The key feature is the study of the net effect, or difference, which can be attributed to the intervention.<sup>3</sup> Impact evaluation is also referred to as outcome or summative evaluation. *In this report, the term 'difference' has been used in place of 'impact' in the key evaluation questions.*

**Process evaluation** usually refers to an evaluation that focuses on activities and events that occur as a program is delivered; that is, things that occur between a specification of inputs and occurrence or measurement of outputs. Process evaluation focuses on how a program was implemented and operates; identifies the procedures undertaken and the decisions made in developing the program; and describes how the program operates, the services it delivers, and the functions it carries out. By documenting the program's development and operation, process evaluation assesses reasons for successful or unsuccessful performance and provides information for potential program improvement or replication.

**Realist evaluation**, at its core, focuses on developing explanations of the consequences of social actions that contribute to a better understanding of why, where, and for whom programs work or fail to work. To this end, realist evaluators place a great deal of emphasis on (a) identifying the mechanisms that produce observable program effects and (b) testing these mechanisms and the other contextual variables or individual characteristics, often referred to as moderators, that may have impacts on the effects that are observed. ... Realist evaluation is a species of theory-driven evaluation. ... According to realist evaluation, programs are theories, they are embedded, they are active, and they are parts of open systems.

**Theory-driven evaluation** (or program theory-driven evaluation) is a contextual or holistic assessment of a program based on the conceptual framework of program theory. The purpose of theory-driven evaluation is to provide information on not only the performance or merit of a program but on how and why the program achieves such a result. Program theory is a set of implicit or explicit assumptions of how the program should be organised and why the program is expected to work. ... Theory-driven evaluation is particularly useful when stakeholders want an evaluation to serve both accountability and program improvement needs.

# Executive Summary

This report outlines the design of a four-year evaluation of the Australian Government's investment in Aboriginal and Torres Strait Islander primary health care, which occurs primarily through the Department of Health's (DOH) Indigenous Australians' Health Programme or IAHP. The evaluation design encompasses the purpose of the evaluation, the evaluation questions, methodological design and rationale, data, implementation plan, analysis of opportunities, limitations and risks, and a communications and dissemination strategy.

## Purpose of the evaluation

### The evaluation will:

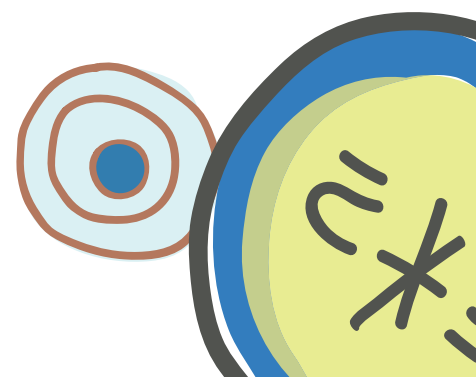
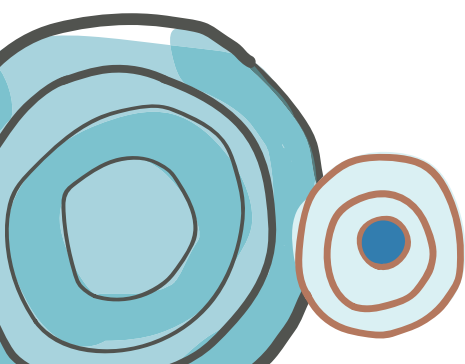
- Demonstrate the difference that the IAHP is making or not making to the primary health care system and Aboriginal and Torres Strait Islander people's health and wellbeing.
- Support the continuous improvement of IAHP policy, planning and decision making.
- Support PHC providers and other key organisations to improve and adapt the quality and ability of their services to achieve better outcomes for the health and wellbeing of Aboriginal and Torres Strait Islander people.

### Key evaluation questions

- 1 How well is the IAHP enabling the primary health care system to work for Aboriginal and Torres Strait Islander people?
- 2 What difference is the IAHP making to the primary health care system?
- 3 What difference is the IAHP making to the health and wellbeing of Aboriginal and Torres Strait Islander people?
- 4 How can faster progress be made towards improving the health and wellbeing of Aboriginal and Torres Strait Islander people?

Aboriginal and Torres Strait Islander people's needs and aspirations for their health and wellbeing, and for comprehensive PHC, are to be central to the evaluation.

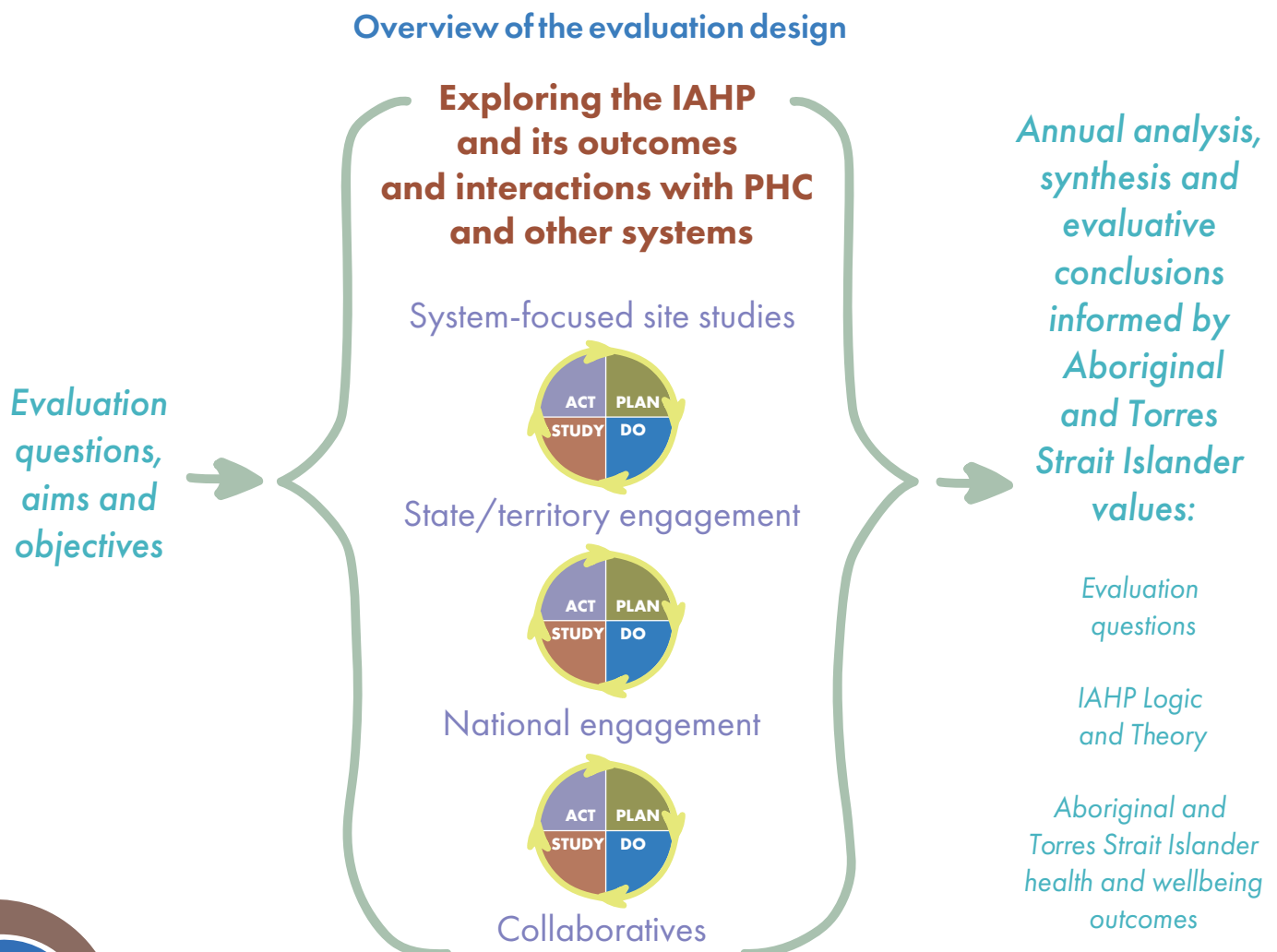
As such, the purpose of the evaluation is to create and expedite real change in Aboriginal and Torres Strait Islander people's health and wellbeing through supporting improvements in the IAHP and its interaction with the primary health care and broader health system. It is also to facilitate learning and action within and between the different levels of the health system – local, regional, state/territory and national.



# Overview of the approach for conducting the evaluation

The evaluation design is illustrated below. The design involves a wide range of stakeholders taking part in developmental, cyclic processes at different levels of the system – local/regional communities and providers in system-focused site studies, organisational stakeholders in state/territory and national engagements, and various groups of stakeholders in collaboratives to address cross-cutting themes – to address the evaluation questions. The repeating cyclic processes are focused on the co-creation of knowledge and, importantly, action. This will enable the evaluation to be responsive to exploring and testing emerging findings.

Overarching analysis, synthesis and national reporting on the evaluation questions, and IAHP logic and theory will occur annually. The emerging findings from the analysis and synthesis will be discussed and interpreted with all evaluation participants in the co-creation and collaborative sessions, and an annual interim national evaluation report and summary version made available.

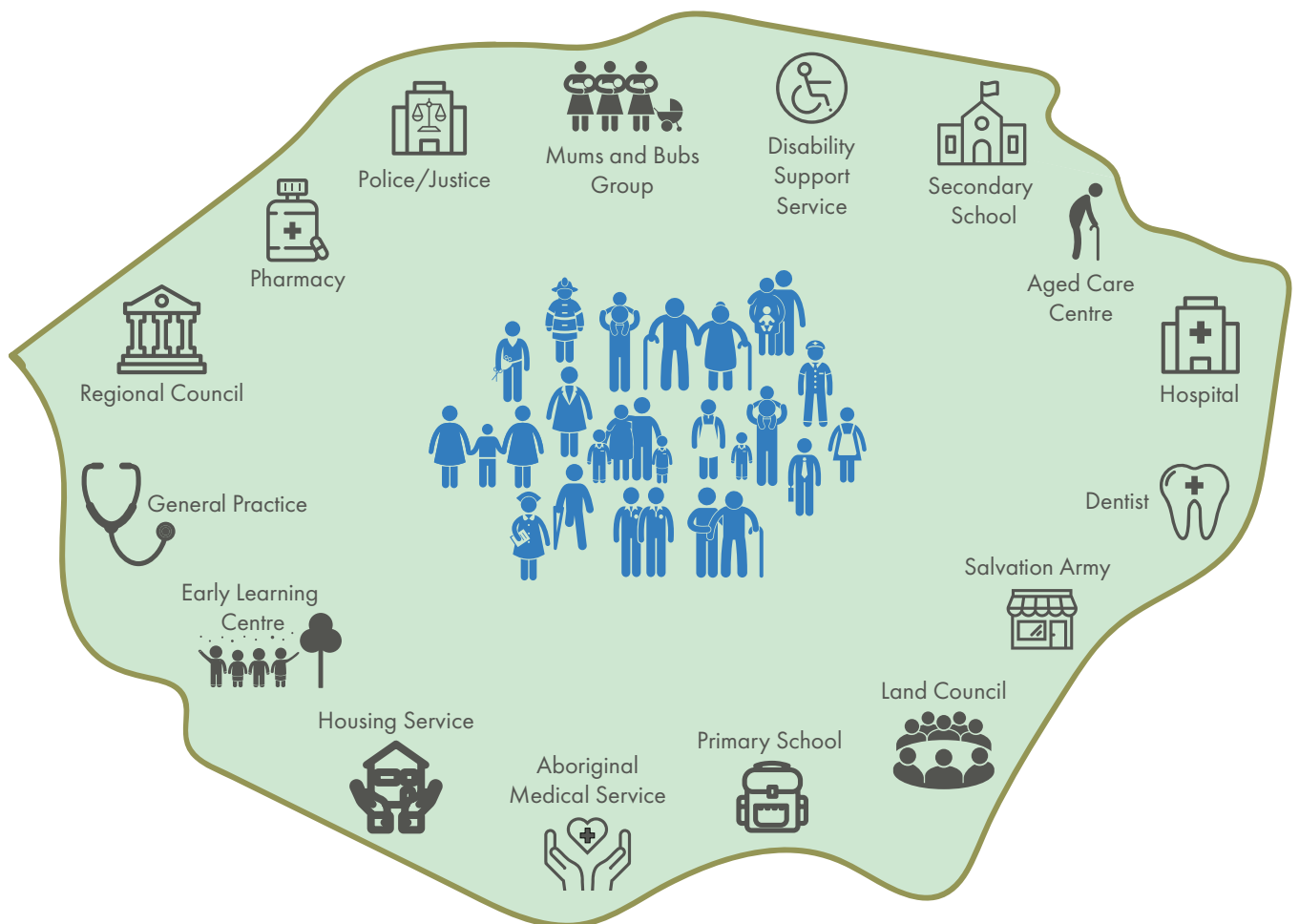


The system-focused site studies will include a range of communities, population groups and providers as illustrated below.

Two levels of involvement will be offered to local/regional sites in recognition of the variance in local circumstances that can impact on capacity to participate in an evaluation – involvement as general

or in-depth sites. General sites will entail a lower level of intensity that includes analysis of nationally available quantitative data for that site, key informant interviews and co-creation sessions. In addition, in-depth sites will involve more intensive data gathering and analysis, and include clinical indicator data, more in-depth interviews and community focus groups.

### System-focused site studies



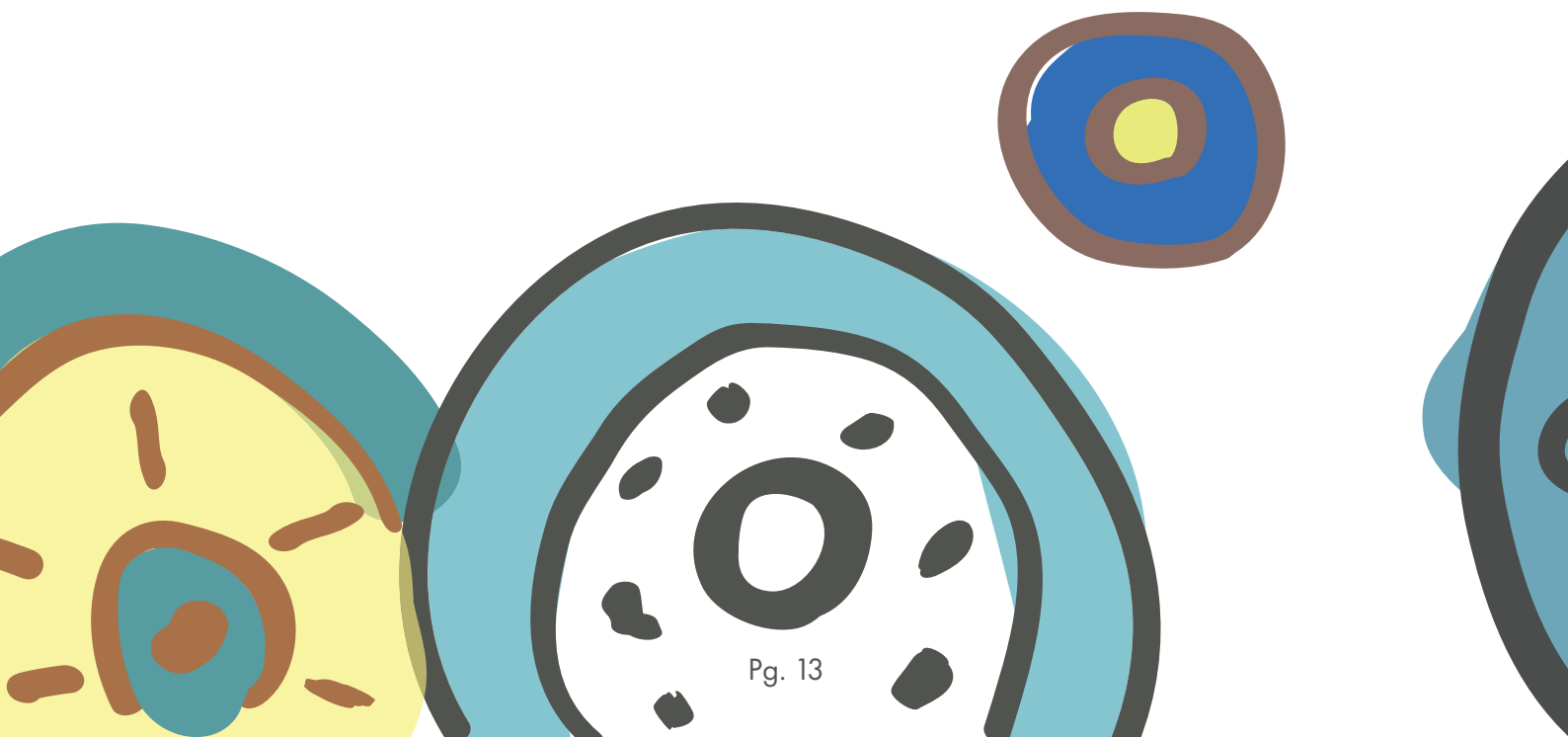
## Key elements of the system-focused site studies:

- Local evaluation governance, including ongoing reflection on the appropriate conduct and local value of the evaluation activities.
- Co-designed tailored evaluation plans within the framework of the overall evaluation design.
- Mapping of the provision of services and IAHP funding and programs, and contextual descriptions.
- Quantitative data – baseline data followed by annually updated data reports, and sessions making meaning of the data.
- Qualitative data-gathering – stories of the experiences of people who use and do not use PHC services, and from people who manage and deliver these services.
- Co-creation sessions – communities and providers coming together to problem solve, analyse and interpret data, discuss and interpret emerging evaluation findings, and identify solutions and actions.
- Capability building, reciprocity and resourcing for participation in the evaluation.

## 20-24 system-focused site studies

The evaluation strongly recommends that between 20 to 24 system-focused site studies occur, with half of these studies general and half in-depth. The two types of sites provide both breadth and an ability to generalise findings (including the ability to compare and contrast) and enable an understanding of what works, for whom and in what circumstances (due to in-depth study). A large number of studies is proposed to account for variations in PHC service models and models of care, geography, population density and diversity, distinct population groups (particularly those that are hard to reach), levels of IAHP funding, and progress on key indicators.

Along with the state/territory and national engagements, 20–24 site studies will achieve the 'evidence' objective for the evaluation by enabling a contextualised, in-depth understanding of the operation and outcomes of the IAHP and its interactions with the PHC and other important systems, programs and factors. State/territory and national engagements, along with the large number of sites, will also achieve the 'change' objective for the evaluation, that is, enable proactive improvements to the IAHP during the four-year evaluation.

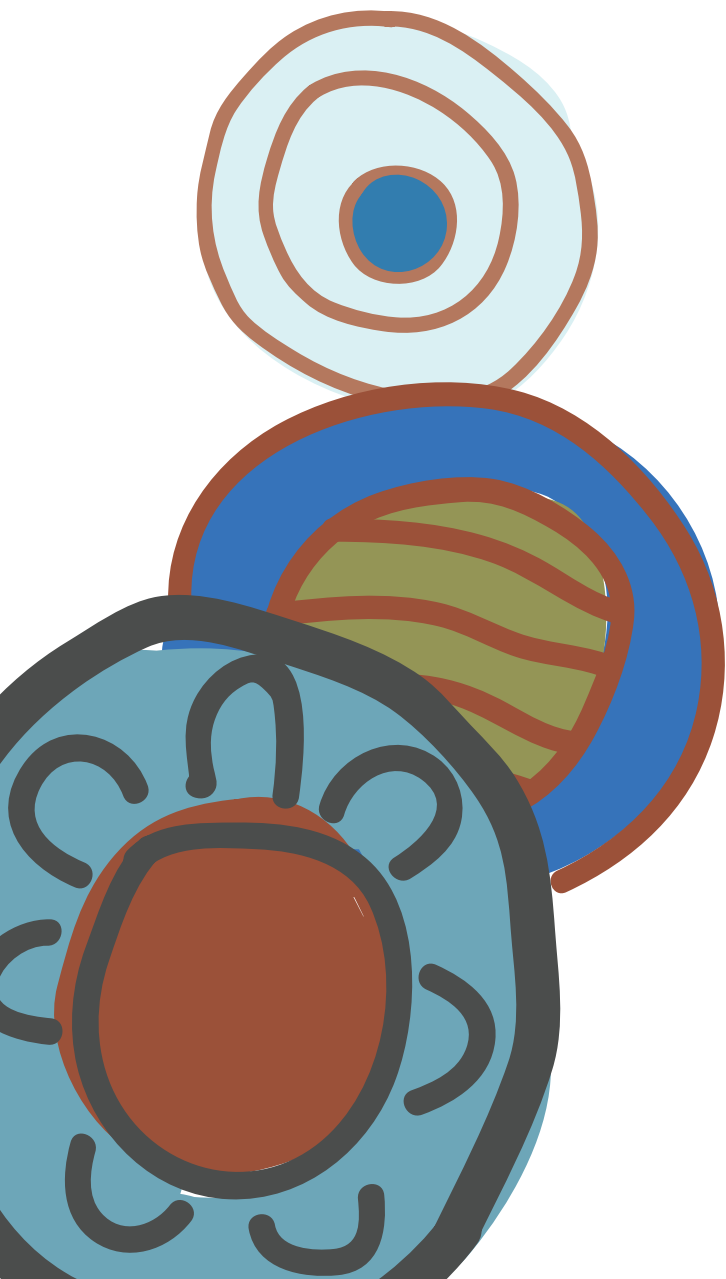


## State/territory and national engagement

The state/territory and national engagements will follow a similar pattern to the site studies – with tailored evaluation plans, descriptions of responsibilities for and provision of IAHP funding and programs, relevant quantitative data analyses, qualitative data gathering, and co-creation sessions.

## The evaluation design has been developed:

- To facilitate co-design, co-creation, relational, honest and empowering processes that are, where possible, led by or co-led with Aboriginal and Torres Strait Islander people, with appropriate co-leadership, resourcing and support from the evaluation team.
- To create multiple opportunities for Aboriginal and Torres Strait Islander people and other key stakeholders – policy makers, practitioners and community members across Australia and the PHC system – to come together and problem solve, analyse and interpret data, discuss emerging evaluation findings, and identify solutions and actions via ‘co-creation’ sessions (site-based) and ‘collaboratives’ (based on emerging themes or issues common to sites, groups, organisations or stakeholders across geographical areas).
- To offer sites varying levels of involvement in the evaluation in recognition of their different capacities and competing priorities.
- To provide recent, analysed data and facilitate data-making meaning sessions so communities and providers can make decisions using their own data.
- To ensure the evaluation is responsive to emerging findings and opportunities to create substantial change, while answering the key evaluation and other questions, and testing the logic and theory of change for the IAHP.



# Plan for conducting the evaluation

## Year 1

### Co-design establishment:

Selecting and establishing the site studies, and engaging national and state/territory stakeholders, will be a key focus of the first year of the evaluation. Health Partnership Forums will assist with the selection of the sites.

Another key focus will be a feasibility analysis of potential quantitative data sources, and the development of a detailed plan for answering the range of evaluation questions, and exploring the IAHP logic and theory, based on the selection of the sites and available quantitative data.

The outputs from Year 1 will be a site selection report; tailored site evaluation plans; service provision maps and contextual descriptions; quantitative and qualitative data protocols, indicators and tools; baseline quantitative data reports; an ethics application; and an interim national evaluation report.

## Years 2 and 3

Co-creation of knowledge and action across the site studies, state/territory and national engagements, and through the emergence of collaboratives:

***The evaluation activity will be guided by a Plan-Do-Study-Act cycle:***

- The 'Plan' component of the cycle involves reflecting on, and adapting as needed, the overall and tailored evaluation plans; development of qualitative fieldwork tools, training and piloting; and the preparation of quantitative data reports.
- The 'Do' component involves co-creation sessions focused on making meaning of data and qualitative fieldwork.
- The 'Study' component involves co-creation and collaborative sessions focused on the production of knowledge and action. Emerging evaluation findings will be presented and analysed as part of these sessions.
- The 'Act' component of the cycle involves the site, state/territory, national and collaborative participants taking action as identified in the co-creation sessions.
- The number of site visits per year, and the visitation processes, will be agreed as part of the co-design with each site. Similarly, the number of state/territory and national engagements will be agreed as part of a co-design process with these stakeholders.





## Year 4 – Transitioning the evaluation and final reporting:

### **Collaboratives**

The need for a collaborative will arise through the analysis of quantitative data and qualitative information gathered through fieldwork across sites, and from the national and state/territory engagements. It may also emerge through stakeholders expressing a strong interest in working on a specific issue that addresses the evaluation aims, objectives and questions described on the first page of the Executive Summary.

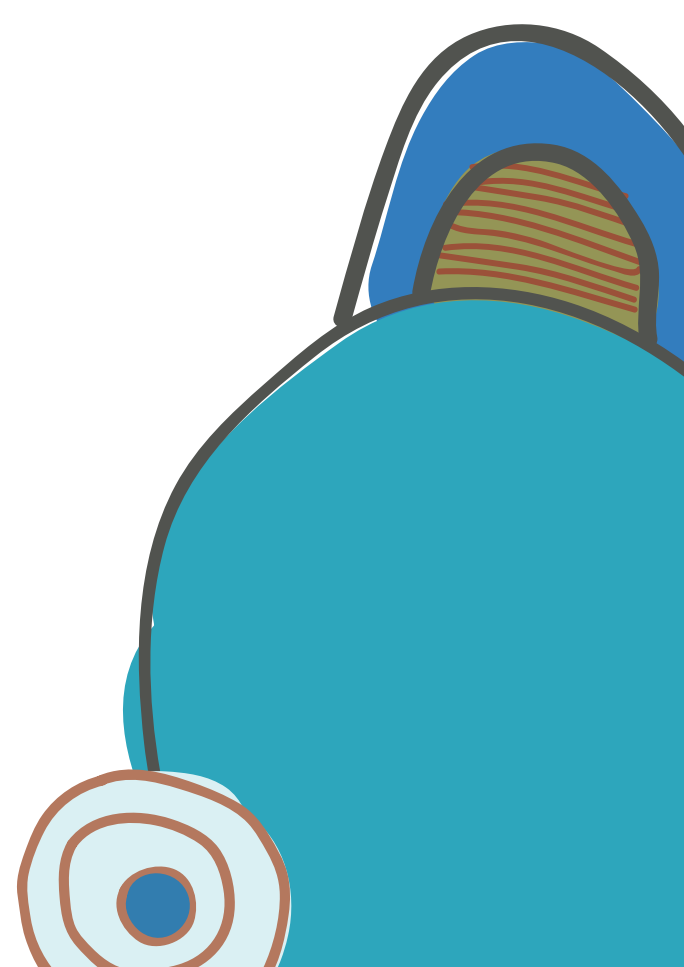
### **Outputs**

The outputs from both Years 2 and 3 are quantitative data reports for each of the sites, for state/territory and national engagements, and for the collaboratives; a progress report to the DOH in March; and an interim national evaluation report and associated summary report in October. There will also be summaries of each of the co-creation and collaborative sessions reported back to participants.

### **Reflection**

Each year or cycle, a visit or engagement will conclude with a reflection process that will check on progress against, and the relevancy of, the tailored evaluation plans, any updates needed for these plans, how well the evaluation process is working, and what could be improved.

As well as continuing the co-creation of knowledge and action, the last year of the evaluation will focus particularly on the evaluation processes valued by sites and other stakeholders, how these could be transferred and sustained, and recommend an approach for monitoring and evaluating the Australian Government's Aboriginal and Torres Strait Islander-specific PHC investment over the longer term. The fourth year will also focus on drafting the final report and working with evaluation participants on the conclusions and recommendations to inform policy settings and program implementation.



## Data

Based on the quantitative data feasibility analysis in Year 1:

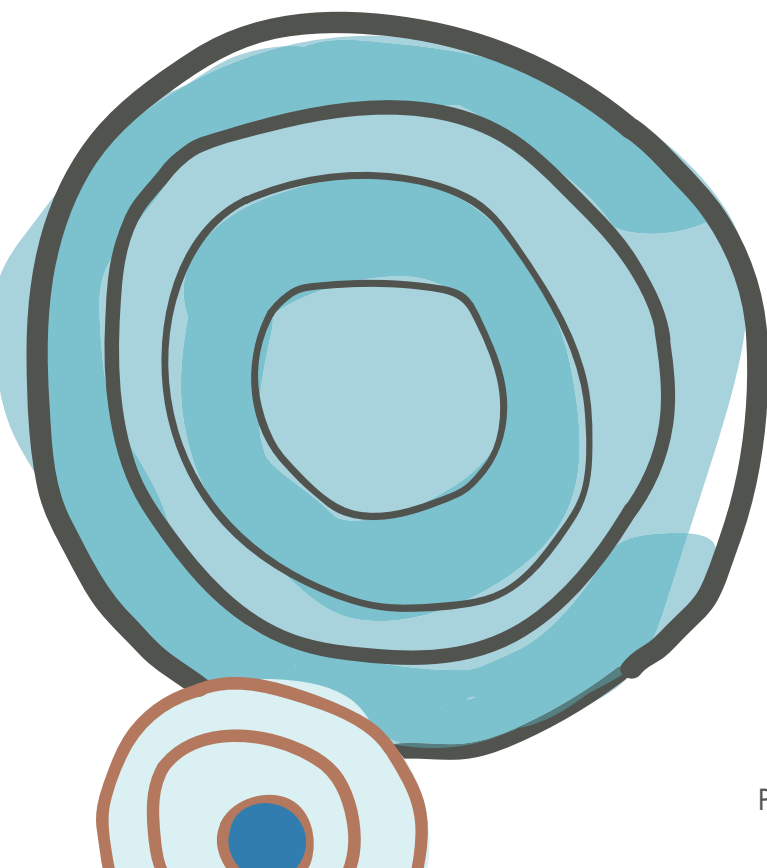
- The general site data reports will include analyses of population data, site characteristics data, IAHP data, nKPI and OSR data and nationally available clinical data. It may include analyses of administrative data and hospitalisations, mortality and morbidity data.
- The in-depth sites will include analysis of additional local and clinical data as well as the data listed for the general sites.

State/territory data reports will include an analysis of site data for their state/territory, data for all sites for all of Australia, and data for all Australia

- National data reports will include an analysis of all the site data and the data for the rest of Australia.
- Site, state/territory and national participants will be provided with an initial baseline quantitative data followed by annual updates.

Analyses of the quantitative and qualitative data will be undertaken at each level – site, state/territory and national – along with relevant comparative analyses to explore factors that can help to explain similarities and differences. These will be reported back and discussed with the participants as part of the making meaning component of the co-creation sessions.

There is already a wealth of existing research literature on Aboriginal and Torres Strait Islander people's health and related factors, and their experiences and perspectives. This information will also be drawn on to explore and understand emerging findings in more detail and to inform proposed actions.



## Monitoring

A monitoring program will be put in place following both the feasibility analysis of potential quantitative data sources, and the development of a detailed plan for answering the evaluation questions in Year 1. The monitoring program will include three components:

- The annual quantitative data reports.
- Tracking the learnings and changes resulting from the evaluation process.
- Tracking the actions undertaken by participants as a result of the co-creation and collaborative sessions.

## Governance

The evaluation will operate under multiple levels of governance – the Department of Health (the commissioner of the evaluation), a Health Sector Co-design Group (HSCG) and a Community Co-design Group (CCG) (national groups that will meet six-monthly), and local governance for each of the sites.

The evaluation team will also establish an independent Technical Reference Group composed of experts in primary health care and evaluation, health systems and systems thinking, Indigenous data, and co-design, design-led and other learning approaches relevant to the evaluation.

A set of guiding ethical principles and identified evaluation standards have already been developed. The evaluation will need ethics approval, and this will likely be sought from the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) Research Ethics Committee given the recent disbandment of the DOH's Human Research Ethics Committee.

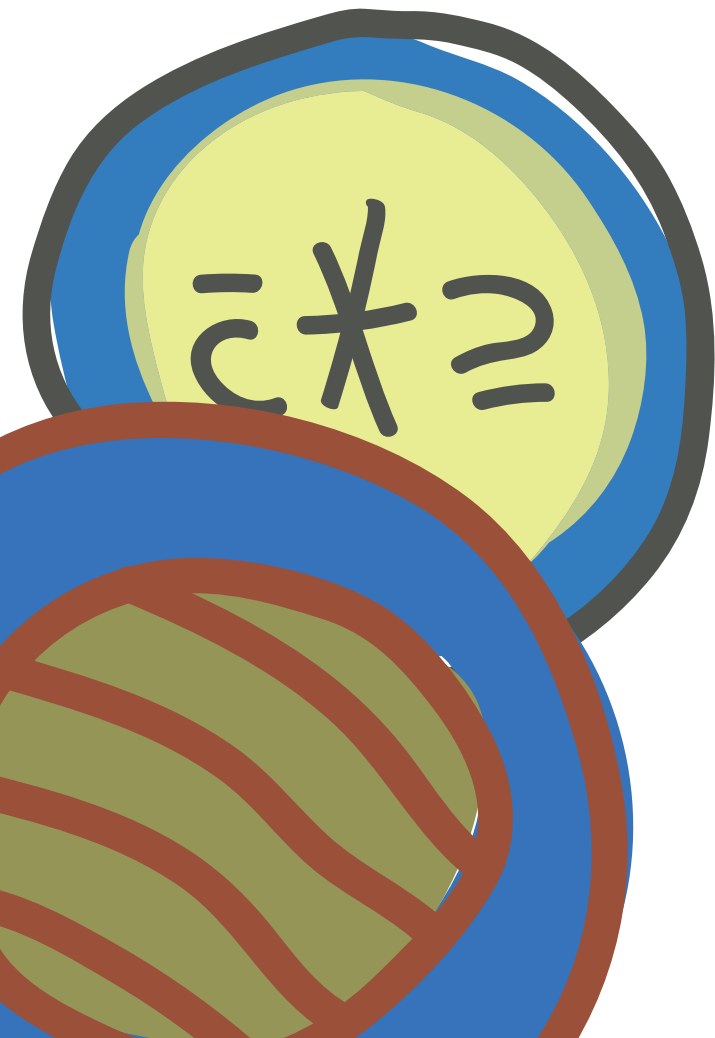
## Methodological approaches

Underpinning the evaluation design is the developmental evaluation approach, complemented by process and impact evaluations. The approach also draws on co-design and co-creation, continuous quality improvement and participatory methods, systems thinking, theory-driven and realist evaluation, evaluation-specific logic, and explicit processes for working with both Aboriginal and Torres Strait Islander and Western knowledge systems. The evaluation recognises the centrality of culture, and the impact of social, economic, political and cultural determinants on health outcomes.

## What people told us is important

***We have designed the evaluation so that we can address substantively what people who were part of its co-design highlighted, namely:***

- There is a great opportunity to make better use of existing data, as although the data are reported into the system not enough information is reported back out to services in a timely fashion.
- While data tells one story, narratives on people's experiences and aspirations are also key. There is a need to look at measures beyond health service coverage and health status.
- It is important to look 'inwards' at the IAHP's policy and grant management processes and systems, as well as assessing service delivery and impacts for the Aboriginal and Torres Strait Islander population.
- Co-designing the problems that the IAHP is intended to solve is key to co-designing the solutions, otherwise different conceptualisations of the problem will most likely result in disparate solutions.
- An ecological (whole-of-system) and adaptable approach to evaluation is needed, one that can respond to important emerging areas of inquiry.
- Strengths-based approaches are vital, ones that share and celebrate the success, strength, resilience and capabilities of Aboriginal and Torres Strait Islander people.





# 1. Introduction and overview

The Australian Government Department of Health (DOH) commissioned the co-design of an evaluation of the Government's investment in Aboriginal and Torres Strait Islander primary health care, which occurs primarily through the Indigenous Australians' Health Programme (IAHP). The co-design process and evaluation design was led by a team headed by Allen + Clarke. The DOH and a Health Sector Co-design Group were involved in the co-design of the evaluation. Engagements with jurisdictional stakeholders and community members also informed the evaluation design.

## 1.1. Purpose of this document

The primary purpose of this document is to set out a design for an evaluation of the IAHP. The proposed design will be considered for approval by the HSCG, the DOH and the federal Minister for Indigenous Health, the Hon. Ken Wyatt AM, MP.

In proposing a design, the document also provides context for the IAHP and its evaluation, summarises the methods used and information gathered through the evaluation co-design process, and provides a rationale for the proposed design.

The evaluation co-design process has been undertaken from October 2017 through to May 2018 and is called 'Phase 1'. If the evaluation design is approved, it will be implemented over Phase 2 – a four-year period.

## 1.2. The evaluation context and rationale

This evaluation is designed to support continuous improvement of the IAHP to accelerate change in improving Aboriginal and Torres Strait Islander people's health and wellbeing, and in closing the gap in health inequality between Aboriginal and Torres Strait Islander people and the rest of the Australian population. The evaluation is also designed to meet the accountability needs of Government and to inform the 2023 revision of the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023* (the Implementation Plan).<sup>4</sup>

The rationale for specific aspects of the evaluation design is discussed throughout the report but this section highlights certain aspects.

### 1.2.1. An evaluation designed to be fit for purpose, methodologically rigorous, credible, feasible and designed to make a difference

The Government seeks to better understand the effectiveness of the IAHP in improving health outcomes for Aboriginal and Torres Strait Islander people directly and through its influence on the rest of the health system. The evaluation questions, scale and mix of methods to gather relevant data at local, regional and national levels align with this purpose, and are designed with the IAHP theory of change and program logic in mind. The evaluation takes a systems approach

that recognises health system complexity, and takes into account the interactions between different forms of investment and multiple contextual influences.

The evaluation design described in this document incorporates and builds on practices that have already proven feasible and successful, such as those detailed and documented in the Sentinel Sites Evaluation.<sup>5</sup> A place-based approach, using a number of geographical sites, provides opportunities to explore how the IAHP operates in practice and interacts with the broader PHC system. Sites will include a range of communities and PHC providers, including Aboriginal Medical Services, general practices and other services, in a range of different contexts. The number of sites allows geographical spread, and the selection criteria will contribute to the utility of data. Data at site level will be provided in a de-identified and aggregate format to protect individuals and individual provider information. As well as addressing important privacy and ethical considerations, aggregated data can build a sense of collective responsibility for impact and build a collaborative environment.

The initial engagement process is designed to provide transparent and detailed information to potential participants, identify willing and capable providers, and support the sustained engagement of both health services and communities over the life of the evaluation. While the rationale for a cyclic and iterative approach is to facilitate data collection, enrich interpretation of the data and facilitate quality improvement, it is also expected that it will generate measurable improvements in the operation of the IAHP. This will contribute to improved Aboriginal and Torres Strait Islander health outcomes and experiences.

Qualitative data collection will support Aboriginal and Torres Strait Islander communities and providers to articulate their needs and aspirations, and this information will inform meaningful criteria on which to base evaluative judgements. Ongoing co-design opportunities, the flexibility of 'collaboratives' as well as sites, and the networks developed during the evaluation will enable additional customised elements to ensure a diversity of perspectives, including from Aboriginal and Torres Strait Islander groups and individuals less engaged with PHC services.

The evaluation design – with its cycles of data collection and analysis, and a range of customised and in-depth data collection on specific issues – supports timely and practical feedback at a regional and national level to enable solutions and improvements to be incorporated into the IAHP.

### **1.2.2. Aligning with Indigenous health evaluation values, principles and frameworks**

The evaluation recognises the centrality of culture to health outcomes and the specific expertise needed to work across diverse Aboriginal and Torres Strait Islander communities. The iterative and cyclic processes are designed to respect the perspectives of Aboriginal and Torres Strait Islander people in interpreting and making sense of data, fostering effective partnerships and joint learning. Although there are inevitable limitations and constraints, the co-design process has created multiple, early and structured opportunities for input from Aboriginal and Torres Strait Islander health sector experts and community groups, and others with expertise, responsibility and leadership roles at all levels of the health system.

The co-design approach is intended to continue as the evaluation evolves. The timelines, including a longer lead-in time for engagement and a staggered approach to initiation in sites, recognises

the need for relationship building and respect for local processes of engagement, governance, capacity, workload and competing responsibilities. Where appropriate, the evaluation will provide resources to help collect, collate and participate in the analysis of local/regional level data.

### **1.3. The evaluation co-design process**

The evaluation design is the result of a multi-layered co-design process that involved participants from across the PHC system – including community members, providers, and state/territory and national organisations – and is informed by relevant literature and documentation.

#### **1.3.1. Ethical principles guiding the co-design process**

The evaluation co-design process has been guided by principles, ethics and standards specific to working with Aboriginal and Torres Strait Islander people and communities, and further informed by additional principles and guidelines for evaluation and co-design, all of which are listed in Appendix 1. Based on a review of these principles, ethics and standards, we identified five ethical principles to guide the evaluation co-design phase:

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.

The rationale for selecting these five principles was outlined in our *Project Plan for Evaluation Co-design* and is included in Appendix 1.

The spirit and intent of these principles will continue to flow through to the implementation of this co-designed and participatory evaluation. How we will continue to adhere to these principles, over Phase 2 of the evaluation, is also described in Appendix 1.

#### **1.3.2. How the evaluation was designed**

This section summarises the activities undertaken in developing this evaluation design. The co-design process is further outlined in our *Project Plan for Evaluation Co-design*, which described co-design as a participatory, collective approach. It explains that co-design for this evaluation will primarily be collaborative, with participants having shared responsibility for its design, but that ultimately decisions would sit with the DOH and the Minister for Indigenous Health.



## Health Sector Co-design Group

The HSCG was established to bring together a wide range of experiences and perspectives from professionals working across the health system, and experts in evaluation, research and co-design (see Appendix 2 for a list of members). More than half the members of the HSCG are Aboriginal or Torres Strait Islander.

The role of the HSCG is (see Appendix 2 for full Terms of Reference):

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

Two meetings of the HSCG have taken place – in December 2017 and April 2018. Members have also been engaged through providing feedback and advice on the evaluation design outputs, including a draft of this report. The Allen + Clarke evaluation team has taken a leadership role with the HSCG in the active discussion, reflection and development of strategies to ensure collective responsibility for the evaluation, and has negotiated with HSCG members during the co-design process.

It is expected that the HSCG will continue through Phase 2 of the evaluation, meeting every six months.

## Community engagement and co-design process

Community engagement involving elements of co-design with Aboriginal and Torres Strait Islander users and non-users of PHC services has also taken place. The process has evolved during Phase 1, and has begun with a community engagement process. It is proposed to work towards the formation of a Community Co-design Group for the implementation of the evaluation in Phase 2.

In Phase 1, in recognition of the time it takes to develop relationships, trust and rapport, and how critical this is to the co-design approach, the focus has been on engaging with groups with whom the evaluation team has existing relationships. This has involved:

- a workshop with the Aboriginal Staff Alliance within the Australian Rural Health Education Network – members of the Alliance are based in University Centres for Rural Health around Australia
- a meeting with Aboriginal and Torres Strait Islander students at the University of NSW
- a meeting with community board members of an Aboriginal Community Controlled Health Service (ACCHS) in Western Australia
- two meetings with board members and management of two ACCHSs in NSW

- a yarning session with users of an ACCHS in NSW
- two sessions with community groups in Queensland (led by Professor Norm Sheehan).

These discussions and yarns have focused on issues and concerns relating to PHC (e.g. where do people access health care, what is working well and not so well), and on what it is important to focus on in an evaluation of PHC. Key messages from these engagements that have informed the evaluation design include:

- There is a distrust of government, a sense that it is not really committed, and this translates to a suspicion in evaluations commissioned by government.
- The problem the evaluation is trying to solve needs to be articulated clearly.
- Data tells one story; narratives on people's experiences and aspirations are also needed.
- The 'co' in 'co-design' needs to translate into Aboriginal and Torres Strait Islander leadership; a genuine understanding of context and world-views, and acknowledging any limitations in understanding; trust, respect, transparency and sharing; strengths-based; and enabling a voice.
- The 'design' in 'co-design' means the evaluation is more than a tool; it is also a relational and empowering process that is tailored to contexts and involves the co-creation of ideas.
- The need for an ecological (whole-of-system) and adaptable approach to evaluation that can include any important areas of inquiry that emerge.
- An interest in knowing more about health care financing – how and where government funding is spent.

The community co-design process will continue into the implementation of the evaluation in Phase 2, where timeframes for the frequency of engagement with a CCG and other local groups will be negotiated and confirmed.

### **Wider stakeholder engagement**

During the evaluation design process, in addition to the more collaborative approaches described above, we engaged with a wider, interested set of stakeholders. This engagement targeted members (formal and ex-officio) of the various state/territory Health Partnership Forums, and other key national organisations/agencies. We also established an online portal through which people could either contact us to share their views on the evaluation design, or respond to a series of high-level questions about the design if people were unable to meet with us.

A list of organisations that participated in these engagements is included in Appendix 3. In total we engaged with 103 participants from 36 organisations or alliances.

Our discussions centred on the purpose of the evaluation, what it should focus on, PHC settings (e.g. service models and community contexts) that should be factored into the evaluation design, and methodological considerations (including potential selection criteria for site-based studies). A summary of what people told us is presented in Appendix 3.

Key messages from these engagements that have informed the evaluation design include:

- The need to look beyond the IAHP by taking a whole-of-system approach that focuses on system linkages, how the various parts of the IAHP fit/work together, and extending beyond the health system by considering the influence of the social and cultural determinants of health.
- The system is complex, and taking a systems-approach will help to determine how it could be more coherent, coordinated and aligned.
- Data is reported into the system/centre but, as not enough information on the data is reported back out to services or in a timely fashion, there is an opportunity to make better use of existing data.
- As well as a need to add to the evidence base for investing in PHC, there is a demand for support in problem solving, and facilitating solutions to long-standing and emergent needs at different levels, from national policy and planning to local service delivery.
- Processes to support systems strengthening need to be sustained beyond the term of the evaluation.
- As well as assessing service delivery, the evaluation needs to look 'inwards' at the DOH's policy and grant management processes and systems.
- There is a need to describe the IAHP in detail, including funding flows for the various elements of the program.
- For some stakeholders, effective engagement in the evaluation may need to be resourced, and less intense evaluative processes over the longer term are favoured.
- It is important to consider context – what was in place before the IAHP and what changed because of it.

## Literature and document review

We reviewed key documents and literature:

- to understand the Government's investment in Aboriginal and Torres Strait Islander PHC, the IAHP and other relevant information
- to ensure the evaluation was working with the most up-to-date information, including on PHC, health systems thinking, system-level evaluation and evaluation in the context of Aboriginal and Torres Strait Islander people's health
- to provide evidence to support the use of methodological approaches, emerging findings and decisions taken during the evaluation.

The literature and documents reviewed included a range of peer-reviewed and non-peer-reviewed literature (e.g. journal articles, book chapters, research papers, IAHP-specific documents, government publications, media releases).

A summary of the literature review is included in Appendix 4. Key messages from the review of literature that have informed the evaluation design include:

On evaluation in the context of Aboriginal and Torres Strait Islander people's health:

- The need to follow a process of meaningful engagement with the individuals and/or communities involved that recognise, protect and advance the rights, cultures and traditions of Aboriginal and Torres Strait Islander people.<sup>6,7,8</sup>
- The importance of methodological approaches that value and build on Aboriginal and Torres Strait Islander expertise, existing community strengths, assets and knowledge systems.<sup>9</sup>
- The value of participatory and collaborative processes with Aboriginal and Torres Strait Islander people that 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.<sup>10</sup>
- 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 the range of views about evaluation and concepts of 'success'.<sup>11,12,13,14</sup>
- The need for customised and tailored approaches, for example, for those not using any health services, transient populations, children and youth, and incarcerated people.<sup>15</sup>
- 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.<sup>16</sup>
- Similarly, ACCHSs are diverse in location, governance, resources and capacity, and thus may need different levels of support to engage.<sup>17</sup>
- The value of place-based approaches, particularly where a high-level of engagement and trust is required 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.<sup>18,19,20</sup>
- The need to avoid the long-standing pattern of deficit framing Indigenous people through data that problematises them, and a need to democratise data.<sup>21,22</sup>

On understanding health care, including PHC, as a complex system:

- Health care systems, including primary care services, are increasingly understood to be components within complex social systems, composed of networks of interconnected components that influence each other, and the outcomes generated from such systems cannot be understood by looking at elements within the system in isolation.<sup>23,24,25,26,27,28</sup>
- 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.<sup>29</sup>

- Evaluation in the context of complex systems 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. Participatory ‘sense-making’ processes are a way to incorporate elements of context, wider systems influences and health system dynamics.<sup>30</sup>
- There is value in locating ‘place’ as the unit of design and analysis with which to evaluate the effectiveness of multiple programs, and to facilitate sustained relationships, trust and cyclic, interactive engagements to gather, use and make sense of data.<sup>31,32</sup>

## Data review

In Phase 1, we have reviewed key administrative and clinical indicator datasets – e.g. Medicare Benefit Schedule (MBS), Pharmaceutical Benefits Scheme (PBS) Co-payment data, Practice Incentive Program (PIP) data, the national Key Performance Indicators (nKPIs) and Online Services Report data – to assess relevance to the evaluation design (see Section 5). Early in Phase 2, a feasibility analysis of the potential quantitative data sources, specification of data extraction requirements and the range of specific methods and indicators for answering the evaluation questions will be undertaken.

### 1.4. Overview of this report

The remainder of this report sets out the evaluation design, including:

- the policy and program context relevant to an evaluation of the IAHP (Section 2)
- the brief that serves as a starting point for the evaluation co-design (Section 3)
- the methodological design, including an overview of the methodological approach and the cyclical design (Section 4)
- the data and information sources that could potentially be analysed to answer the evaluation questions (Section 5)
- analysis and reporting processes (Section 6)
- evaluation implementation and management issues, including an implementation plan, governance arrangements, principles, standards and ethics, and opportunities, limitations and risks (Section 7)
- a communications strategy (Section 8).



## 2. Program and policy context

This section provides the policy context surrounding the IAHP, describes the program itself, and situates it within the broader context of PHC for Aboriginal and Torres Strait Islander people.

### 2.1. Policy context

The 1989 *National Aboriginal Health Strategy* was a landmark document providing an agreed direction for Aboriginal and Torres Strait Islander health policy in Australia. Building on this, the 1991 *Aboriginal and Torres Strait Islander Health Goals and Targets* were designed to reflect the holistic approach to understanding Aboriginal and Torres Strait Islander health by setting interim goals and targets across health outcomes, access, health support, education, and training.

Over 1996 to 1999 all jurisdictions signed Aboriginal and Torres Strait Islander Health Framework Agreements. These led to the establishment of partnership forums between the Commonwealth Government, the State or Territory government, the National Aboriginal Community Controlled Health Organisation (NACCHO) or its state/territory affiliate, and the Aboriginal and Torres Strait Islander Commission to collaborate on policy and planning decisions affecting Aboriginal and Torres Strait Islander health. In 1999 all jurisdictions began to report on their progress to realising commitments in the Framework Agreements and from 2004-05 this reporting has been incorporated into reports against the Implementation Plans for the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013*. The *National Strategic Framework* set out agreed policy priorities but did not impose specific targets or benchmarks, enabling state and territory governments to develop specific strategies to support the overall goals and objectives within the Framework.

In December 2007, the Council of Australian Governments (COAG) agreed to a partnership between all levels of government to work with Aboriginal and Torres Strait Islander communities to achieve the target of closing the gap in key outcomes between Indigenous and non-Indigenous Australians.<sup>33</sup> COAG's Closing the Gap (CtG) strategy was developed by Australian governments following their signing of the *Close the Gap Statement of Intent* from March 2008 onwards.<sup>34</sup>

In November 2008, the *National Indigenous Reform Agreement (Closing the Gap)* set out the original objectives, outcomes, outputs, performance indicators and performance benchmarks agreed by COAG in its CtG commitments.<sup>35</sup> Further, it provided a link to other national agreements and national partnership agreements, which include elements that will contribute to the implementation of CtG measures.

Specific CtG targets were developed, including to reduce inequalities in Aboriginal and Torres Strait Islander life expectancy and childhood mortality. The latest *Closing the Gap: Prime Minister's Report 2018* found that, of the two health-focused targets, the Aboriginal and Torres Strait Islander child mortality rate had significantly improved, while the life expectancy target had seen minimal improvement.<sup>36</sup> The following graph (Figure 1) and table (Table 1) chart progress against the two CtG health targets.

Target: Halve the gap in mortality rates for Indigenous children under five within a decade (by 2018)<sup>37</sup>

Figure 1: Childhood mortality rates, 0-4 years



Target: Close the gap in life expectancy between Indigenous and non-Indigenous Australians within a generation (by 2031)<sup>38</sup>

Table 1: Life expectancy at birth

	Indigenous		Non-Indigenous		Gap (years)	
	Males	Females	Males	Females	Males	Females
<b>2005–2007</b>	67.5	73.1	78.9	82.6	11.4	9.6
<b>2010–2012</b>	69.1	73.7	79.7	83.1	10.6	9.5

Source: ABS, 2013. Life tables for Aboriginal and Torres Strait Islander Australians, 2010–2012, ABS Cat. No. 3302.0.55.003

Against this policy context, the first ACCHS was established in Redfern (Sydney) in 1971 in response to a range of barriers inhibiting Aboriginal access to mainstream PHC services and in recognition of the principles of self-determination.<sup>39</sup> ACCHSs are PHC services that have been initiated by local Aboriginal communities to deliver holistic and culturally appropriate care to people within their communities. Their board members are elected from the local Aboriginal community. NACCHO, the national peak body for ACCHSs, currently represents 143 ACCHSs



across the country and, together with the national and state/territory peak bodies, these services are an integral part of the health system participating as partners with governments in policy development, planning and service delivery.

## 2.2. Health reform in the context of Aboriginal and Torres Strait Islander health<sup>40</sup>

The Australian Government has acknowledged that 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. It has also acknowledged that concerted and long-term effort across all levels of the health system is needed to bring about the desired changes. Recent reforms have focused both on improving access to services, and on the quality and efficiency of services, by placing the consumer – not the provider – at the centre of the health system.

The *National Aboriginal and Torres Strait Islander Health Plan 2013–23* (the Health Plan)<sup>41</sup> and the accompanying Implementation Plan<sup>42</sup> were developed with the intention of providing a long-term, evidence-based policy framework to reduce Indigenous health inequality. The Health Plan has a vision that:

*The Australian health system is free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable. Together with strategies to address social inequalities and determinants of health, this provides the necessary platform to realise health equality by 2031.*<sup>43</sup>

Through this vision, the Implementation Plan reflects the Australian Government's health reform agenda by promoting strategies that are consumer-centric and seek:

- to empower Aboriginal and Torres Strait Islander people to take control of their own health
- to address racism and inequality, and emphasise the centrality of culture in the health of Aboriginal and Torres Strait Islander people
- to make the health system more responsive to the clinical health care needs as well as the social and emotional wellbeing of Aboriginal and Torres Strait Islander Australians.

The Implementation Plan addresses the broad changes needed to make the health system more comprehensive, culturally safe and effective. It has a strong focus on prevention, as well as on improving the patient journey of Aboriginal and Torres Strait Islander people through the health system. It also focuses on supporting local and regional responses to identified needs, and is a key element of the Government's approach to Closing the Gap.

Another key document linked to the Health and Implementation Plans is the Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health: A National Approach to Building a Culturally Respectful Health System.<sup>44</sup> This document is focused on strengthening the cultural respect of health staff and organisations through addressing six domain areas – whole of organisation approach and commitment; communication; workforce development and training;

consumer participation and engagement; stakeholder partnerships and collaboration; and data, planning, research and evaluation.

### **2.3. The Aboriginal and Torres Strait Islander PHC context**

Primary health care includes services provided by general practitioners, dental practitioners, nurses, Aboriginal and Torres Strait Islander health workers, pharmacists and other allied health professionals. Aboriginal and Torres Strait Islander people access PHC services through 5,700 private general practices across Australia, and through services specifically established to meet their needs. These include approximately 143 Aboriginal Community Controlled Health Services and approximately 40 other Aboriginal Medical Services, usually managed by state/territory governments. Around half of the Aboriginal and Torres Strait Islander population accesses services through private general practices and around half through these Indigenous-specific PHC organisations.

Other important organisations focused on improving the overall effectiveness of the health system for Aboriginal and Torres Strait Islander people are national and state/territory peak bodies for ACCHSs – the National Aboriginal Community Controlled Health Organisation (NACCHO) and affiliate bodies in states/territories. These peak bodies (or sector support agencies) also play an important role in addressing the social and cultural determinants of health through their work in the community, and by integrating health services with aged care, education and disability support.

#### **2.3.1. The role of primary health care**

Facilitating improved health outcomes through accessible, effective and efficient PHC services is fundamental to reducing health inequalities between Aboriginal and Torres Strait Islander people and other Australians.

Comprehensive PHC is a core part of any health system, with international evidence suggesting that a strong PHC system correlates with better health outcomes, a reduced national health care expenditure, and lower infant mortality rates.<sup>45</sup> There is also evidence that PHC contributes to reduced morbidity from chronic disease through both primary and secondary prevention and appropriate referral and follow-up.<sup>46</sup> Increased PHC resources are also shown to offset some of the harmful effects of socio-economic disadvantage and inequality.

NACCHO contextualises comprehensive PHC 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.<sup>47</sup> There is a rich literature on what constitutes effective and comprehensive PHC, enablers and barriers to good care, and what Indigenous Australians value about primary care.<sup>48,49,50,51,52,53,54,55</sup> This includes work to identify the core elements of PHC required to achieve equity of access in rural and remote Australia.<sup>56,57</sup>

There is considerable variation in the effectiveness of PHC delivery across the health system and this represents a challenge for realising the potential benefits of Australian Government funding and policy settings. The same national policy and funding settings can yield different results at the local level, so health benefits for individuals and communities may not be realised equally in terms

of health system performance and outcomes. Access barriers to PHC by Aboriginal and Torres Strait Islander people include economic considerations, transport, cultural attitudes or beliefs, language and communication issues, the cultural appropriateness of services and paucity of Indigenous staff.<sup>58</sup>

### **2.3.2. Addressing colonial history and the social determinants of health and wellbeing**

It is important to address the social and cultural determinants of health as there are many drivers of ill health that lie outside the direct responsibility of the health sector.<sup>59</sup>

A further fundamental contextual factor is that the health and wellbeing of many Aboriginal and Torres Strait Islander Australians is still affected by a colonial history that separated people from their land and culture, and exposed them to racism, social exclusion and discrimination, leading to poorer social, economic and health and wellbeing outcomes compared to non-Indigenous Australians. The experience of the Stolen Generations, those Aboriginal and Torres Strait Islander children who throughout the twentieth century were forcibly removed from their families as a result of government policies, has also left a legacy of loss and trauma that continues to have adverse effects on Indigenous individuals, families and communities.<sup>60</sup>

This reality requires action across key social determinants such as health, housing, education, employment, the alignment of program goals across sectors of government and the development of collaborative cross-sectoral programs at a local level. Social and cultural determinants of health – such as education, employment, justice, income and housing – contribute to around a third of the health gap between Indigenous and non-Indigenous Australians.

## **2.4. The Indigenous Australians' Health Programme**

The Australian Government's primary investment in Aboriginal and Torres Strait Islander health is through the Indigenous Australians' Health Programme established on 1 July 2014. The IAHP consolidated four previous funding streams: primary health care; child and maternal health programs; Stronger Futures in the Northern Territory (Health); and programs covered by the Aboriginal and Torres Strait Islander Chronic Disease Fund.<sup>61</sup>

The objective of the IAHP is to provide Aboriginal and Torres Strait Islander people with access to effective, high-quality, comprehensive, culturally appropriate PHC services in urban, regional, rural and remote locations across Australia. Services are delivered through ACCHSs, wherever possible and appropriate, as well as services across the entire health system that deliver comprehensive, culturally appropriate PHC.

The DOH has developed a program theory and logic for the IAHP which is included in Appendix 5.

Through the IAHP the Australian Government:

1. Funds organisations to deliver comprehensive PHC to Aboriginal and Torres Strait Islander people.
2. Funds Aboriginal and Torres Strait Islander-specific initiatives delivered through ACCHSs, state- and territory-managed Aboriginal Medical Services, non-government organisations and the mainstream system (e.g. private general practices).

3. Funds Primary Health Networks (PHNs) to commission mental health, alcohol and other drug (AOD) services for Aboriginal and Torres Strait Islander people.
4. Seeks to influence the health system so that it works better for Aboriginal and Torres Strait Islander people.

All activities under the IAHP must align with the five themes of the IAHP Program Guidelines:

1. PHC services, both provision and support for effective primary care.
2. Improving access to PHC for Aboriginal and Torres Strait Islander people.
3. Targeted health activities.
4. Capital works.
5. Governance and system effectiveness.

The IAHP is implemented as part of a broader complex health system. The program must align with the implementation of the *National Aboriginal and Torres Strait Islander Health Plan*,<sup>62</sup> which focuses on systematic service improvements and addressing geographic disparities. Program implementation also needs to align with broader health system effectiveness measures, such as electronic health records and the establishment of the PHNs and the planning and coordination opportunities they represent.

There are currently eight IAHP administered sub-program activities with a number of specific activities included within them (outlined in Table 2). The IAHP activities aim to improve the health of all Aboriginal and Torres Strait Islander people through a variety of activities focused on local needs as well as targeted responses to specific health issues.

**Table 2: Activities funded through IAHP**

IAHP themes (Program Guidelines)	IAHP administered sub-program activities	Activities included
PHC services	<b>Indigenous primary health care services</b>	Indigenous PHC (continuity funding for comprehensive PHC) Indigenous New Directions Integrated Early Childhood Healthy for Life New Directions – Expansion, Australian Nurse Family Partnership Program Connected Beginnings
Improving access to PHC for Aboriginal and Torres Strait Islander people	<b>Indigenous access</b>	Remote Area Health Corps Medical Outreach Indigenous Chronic Disease Programme Integrated Team Care Services of Concern PBS CtG Co-payment

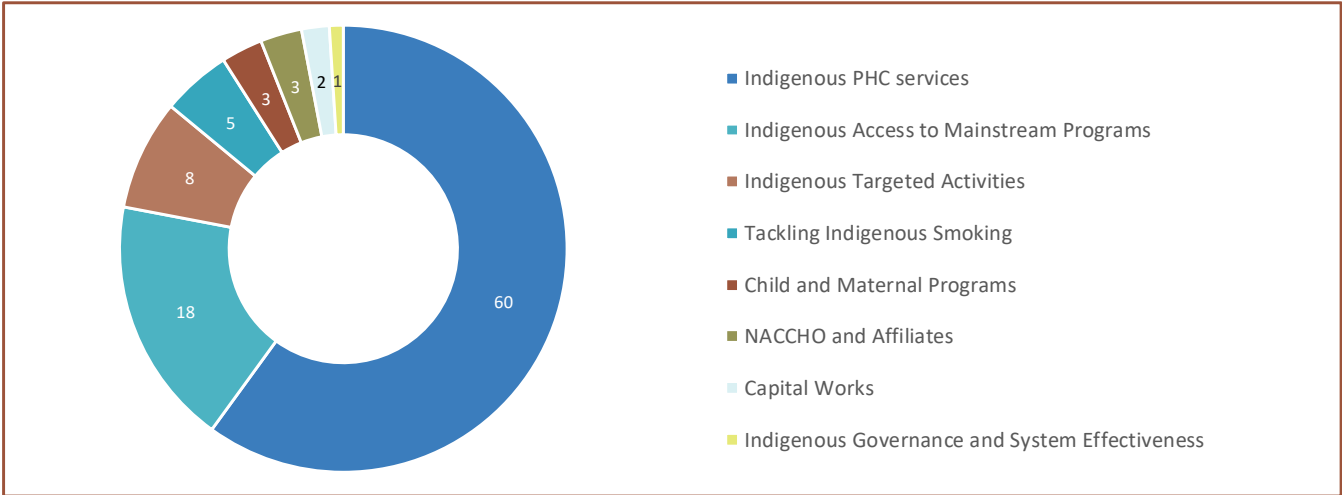
IAHP themes (Program Guidelines)	IAHP administered sub-program activities	Activities included
Targeted health activities	<b>Indigenous targeted activities</b>	Indigenous Renal Indigenous Ear Health Indigenous Eye Health Indigenous Cardiac Care Indigenous Rheumatic Fever Strategy Indigenous Health Promotion Indigenous Health Protection Bowel Cancer Screening Sexual Health, Nutrition Oral Health, Youth Indigenous Chronic Disease Programs Workforce
	<b>Indigenous smoking</b>	Tackling Indigenous Smoking program
	<b>Indigenous mental health</b>	Funding provided in response to the National Mental Health Commission's Review of mental health services (2015) for Indigenous-specific mental health services commissioned through Primary Health Networks
Capital works	<b>Indigenous capital works</b>	Capital works for building refurbishment, etc of ACCHS clinics and associated staff accommodation including Service and Maintenance Program
Governance and effectiveness systems	<b>Indigenous governance and system effectiveness</b>	National Indigenous Continuous Quality Improvement Indigenous Monitoring and Evaluation Indigenous Remote Service Delivery Traineeship Aboriginal Health Ministers' Advisory Council contribution Implementation Plan Regionalisation
	<b>NACCHO and affiliates</b>	Includes peak body and affiliate funding agreements, and other costs associated with supporting affiliate activities

**2.4.1. IAHP and PHC funding**

The IAHP is primarily governed, administered and funded by the DOH through the Indigenous Health Division. As at 1 January 2018, 230 organisations were funded directly by the DOH under the IAHP, including 138 ACCHSs. Of these, 163 organisations were funded under the IAHP to deliver comprehensive PHC, 130 of which were ACCHSs. The IAHP also funds specific programs through grants to both Indigenous and non-Indigenous PHC organisations. Total expenditure on the IAHP was \$780.2 million in 2016–17.<sup>63</sup> The majority of expenditure was for the provision of comprehensive PHC (see Figure 2).

*We are interested in knowing more about health care financing – how and where government funding is spent.*

**Figure 2: Indigenous Australians’ Health Programme, 2016–17 expenditure (%)**



Source: DOH, Information provided to the HSCG, 2018

Funding for the IAHP continues to grow, most recently increasing by \$200 million in the 2018–19 Budget to a total of \$3.9 billion over four years from 2018–19. A new funding model for the IAHP is currently being developed.

To put the IAHP expenditure into context, total expenditure on health in Australia was \$170.4 billion in 2015–16, of which \$114.6 billion was government expenditure (\$70.2 billion of this was Australian Government expenditure and \$44.4 billion was state/territory government expenditure).

For PHC, total government expenditure in 2015–16 was \$34.6 billion, and \$25.6 billion of this was Australian Government expenditure.<sup>64</sup> Non-government sources of PHC expenditure totalled \$24.6 billion, giving a total PHC expenditure of \$59.2 billion. Thus, IAHP expenditure is between 1–2 per cent of total PHC expenditure.

It is not possible to identify how much of this expenditure is for PHC for Aboriginal and Torres Strait Islander people specifically. Within mainstream programs, the expenditure per person for

both the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme is lower for Indigenous Australians than for non-Indigenous Australians. Of the approximately \$10 billion expended per year under the PBS, an average of around \$34 million is expended on Indigenous health, while in 2015–16, MBS expenditure on the 22 Indigenous-specific items totalled \$67.5 million<sup>65</sup> (Aboriginal and Torres Strait Islander people access other non-Indigenous specific MBS items and PBS subsidies in addition to these).





## 3. Evaluation brief

This section outlines the aims, objectives and vision for the evaluation, the evaluation questions, scope and alignment with other IAHP evaluation and related activity. It draws strongly on the initial brief set by the DOH, and subsequently on co-design processes with other stakeholders.

### 3.1. Aims and objectives of the evaluation

#### 3.1.1. Aims

The evaluation is to meet the accountability needs of the Australian Government and provide timely information and evidence to support the continuous improvement of the Indigenous Australians' Health Programme to accelerate change in improving Aboriginal and Torres Strait Islander people's health and wellbeing and to meet the Closing the Gap targets. Evaluation findings are also to inform the 2023 revision of the Implementation Plan.

The evaluation must also facilitate the adaptive management and continuous improvement needs of PHC organisations and other key stakeholders across the service system, and ensure that Aboriginal and Torres Strait Islander communities are able to articulate their needs and aspirations.

Importantly, the evaluation needs to contribute to real change in Aboriginal and Torres Strait Islander people's health and wellbeing through supporting improvements in the IAHP and its interaction with the PHC and the broader health system. It also aims to facilitate learning between the different levels of the health system – local, regional, state/territory and national.

#### 3.1.2. Objectives

The evaluation objectives are:

1. To evaluate the appropriateness and effectiveness of the Australian Government's investment in Aboriginal and Torres Strait Islander PHC considering the broader PHC system in a range of contexts.
  - a. Understand and identify the enablers, barriers and changes required at different levels of the system, in order to improve health outcomes for Aboriginal and Torres Strait Islander people.
2. To support informed policy and planning decision making that will enable improvements to be incorporated into the IAHP as it is implemented through practical, timely and evidence-based findings and recommendations.
  - a. Promote system learning and adaptation throughout the implementation of the evaluation.

3. To develop an improved understanding both of consumers (people who use and do not use PHC services) and of health care providers' perspectives and experiences of the health system in terms of what they value.
4. To recommend an approach for monitoring and evaluation over the longer term (5–10+ years). This is to include consideration of developing a future accountability framework that measures the public value and health outcomes of the Australian Government's Aboriginal and Torres Strait Islander-specific PHC investment.

### **3.1.3. Vision**

The DOH seeks an evaluation that directly contributes to the wider Australian Government's health reform agenda, specifically one that:<sup>66</sup>

- Addresses the variable effectiveness of PHC delivery across the health system through mobilising stakeholders to work together, and through leadership and opportunities to build broader linkages and partnerships.
- Creates enabling structures and opportunities for meaningful collaboration across the health system to shift it towards placing Aboriginal and Torres Strait Islander people at the centre of their care.
- Is well oriented to understanding that social and cultural determinants of health (such as education, employment, justice, income and housing) contribute to around a third of the health gap between Indigenous and non-Indigenous Australians.
- Evaluates the effectiveness of PHC resources in meeting Aboriginal and Torres Strait Islander people's holistic view of health. This includes consideration of the barriers (such as systemic racism, cultural competency of providers) and enablers (such as approaches that empower and strategies which address social inequalities and determinants of health) to achieving the Health Plan's vision of health equality for Aboriginal and Torres Strait Islander Australians.
- Uses the evaluation process as an opportunity for co-design and for a better understanding of the supporting structures and approaches that could underpin the use of co-design approaches more broadly (e.g. developing policy), as part of accelerating progress towards achieving the Health Plan's vision.

## **3.2. Evaluation questions**

The key evaluation questions (KEQs) are:

1. How well is the IAHP enabling the PHC system to work for Aboriginal and Torres Strait Islander people?
2. What difference is the IAHP making to the PHC system?
3. What difference is the IAHP making to the health and wellbeing of Aboriginal and Torres Strait Islander people?

4. How can faster progress be made towards improving the health and wellbeing of Aboriginal and Torres Strait Islander people?

The evaluation sub-questions are shown in Figure 3, and are provided in Appendix 6.

The questions are aligned to the KEQs (vertically) and to the elements of a health system (horizontally). The health system elements are based on the *Health System Dynamics Framework*.<sup>67</sup> The questions align to the element which they primarily relate to, acknowledging that many questions relate to other health system elements. Visualising the evaluation questions in this way helps to determine the coverage of the questions across elements of the health system. Within the *Health System Dynamics Framework* 'resourcing' encapsulates financing, human resources, infrastructure and supplies, and knowledge and information.

### 3.3. Scope of the evaluation

The scope of the evaluation is the Australian Government's investment in Aboriginal and Torres Strait Islander PHC, with a focus on the IAHP. This scope includes investment in PHC services delivered by Aboriginal Medical Services and non-Indigenous specific services. It also includes investment in activities beyond services, such as in governance and policy (including within the DOH's Indigenous Health Division), designed to support the IAHP and strengthen the PHC system.

The IAHP's interactions with, and influence on, other parts of the PHC and wider health systems are also in scope, including:

- other funding for Aboriginal and Torres Strait Islander PHC (for example, the MBS and PBS) and linked programs including National Partnership Agreements which provide for payments from the Commonwealth to states/territories to support the delivery of specific projects (e.g. rheumatic fever and trachoma control services)
- inter-relationships between the IAHP and PM&C's mental health and AOD programs
- inter-relationships between, and the influence of, the IAHP and the social and cultural determinants of health.

While an evaluation of the PHC system is out-of-scope, the evaluation will assess the extent to which the IAHP is contributing to improving the PHC system, and whether these improvements, and the IAHP itself, are translating into better health and wellbeing outcomes for Aboriginal and Torres Strait Islander people. The evaluation will develop a framework for monitoring and assessing the worth of the IAHP based on Aboriginal and Torres Strait Islander people's values and measures of success.

Similarly, while evaluating the impact of the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023* is out of scope, the evaluation will look at inter-relationships between the Implementation Plan, which the IAHP funds, and the IAHP itself.<sup>68</sup>

**Figure 3: Evaluation sub-questions by KEQ and health system element**

<p>How can faster progress be made towards improving health and wellbeing for Aboriginal and Torres Strait Islander people?</p>	<p>How can the reach of PHC be extended to cover hard-to-reach groups (due to geography and/or population factors)?</p> <p>What is working well?</p> <p>How can successes be shared more broadly with IAHP funded services and across the PHC system to celebrate and support learning?</p>		<p>What needs to change at different levels of the health system?</p> <p>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?</p> <p>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?</p> <p>What needs to change in other policy areas (e.g. education, employment, social security, housing, food)?</p> <p>How can knowledge and information best be used across the IAHP to inform and improve practice?</p>	<p>How could IAHP funding and grant-making processes be improved?</p>	<p>To what extent is the IAHP contributing to the active participation of Aboriginal and Torres Strait Islander people in Australian society?</p>	
<p>What difference is the IAHP making towards improving health and wellbeing for Aboriginal and Torres Strait Islander people?</p>	<p>To what extent does the IAHP support people to confidently access and navigate the PHC system?</p>	<p>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?</p> <p>Are the IAHP initiatives changing peoples' lives for the better in terms of health and wellbeing outcomes?</p> <p>How is this changing over time?</p> <p>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?</p>	<p>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)?</p>	<p>Are the funded IAHP initiatives durable? Are they the right fit?</p> <p>Are they supplementing other PHC service delivery well?</p> <p>To what extent is the evaluation co-design and methodological approaches achieving the aims of the evaluation?</p>		
<p>What difference is the IAHP making to the PHC system?</p>						
<p>How well is the IAHP enabling the PHC system to work for Aboriginal and Torres Strait Islander people?</p>	<p>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?</p> <p>To what extent is the PHC service system (including IAHP funded services) oriented and/or becoming more oriented towards Indigenous consumers' values and priorities?</p> <p>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?</p> <p>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?</p> <p>Which cohorts do we know least about?</p>	<p>What do Aboriginal and Torres Strait Islander people value in terms of service delivery and design?</p> <p>How do Aboriginal and Torres Strait Islander people experience the health system?</p> <p>Who is accessing PHC services and who is missing out?</p> <p>Where is there unmet need?</p> <p>What is working well, for whom and in what contexts and conditions? Why?</p> <p>To what extent are communities enabled to input to the design of local health service delivery?</p> <p>To what extent are individual people enabled to manage their own health?</p>	<p>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?</p> <p>How well are governance and management processes across the system enabling implementation of the IAHP?</p> <p>What are the barriers?</p>	<p>How is the investment in Indigenous PHC being implemented at the different levels of the system?</p> <p>What does it look like in practice?</p> <p>How well is knowledge and information used across the IAHP to inform and improve practice?</p>		
	<p>Service delivery</p>	<p>Population</p>	<p>Leadership and governance</p>	<p>Resourcing</p>		<p>Goals</p>

The evaluation will not undertake IAHP program-specific evaluations or consider particular IAHP programs in isolation. It will, however, draw on existing IAHP evaluations and reviews as sources of evidence, and will also consider policy, provider and community perspectives as to how well specific programs are working as part of the IAHP, and whether they are contributing to the desired system outcomes.

Questions being explored by the economic evaluation of the IAHP are out of scope, but those raised by the economic evaluation that may be usefully explored as part of the IAHP evaluation will be considered (see Section 3.4.1).

## **3.4. Alignment**

Appendix 7 provides a brief description of all IAHP program-specific evaluations and other related activity, and will be drawn on as appropriate for the purposes of this evaluation. This section provides information regarding the alignment of this evaluation with the economic evaluation of the IAHP and NSW Health's *Program and Services Evaluation Framework for Aboriginal and Torres Strait Islander Community Health*.<sup>69</sup>

### **3.4.1. Economic evaluation**

An economic evaluation of the IAHP, centred around return on investment in primary health care, is planned to occur concurrently with the design and implementation of this evaluation. The IAHP economic evaluation considers health benefits, health outcomes, and the costs of both PHC and activities and programs for Aboriginal and Torres Strait Islander people.

The purpose of the economic evaluation is to inform future investment under the IAHP. The evaluation is expected to develop policy recommendations that consider:

- the return on investment that the IAHP delivers through such factors as health benefits and outcomes, social returns and broader economic outcomes
- the relative costs of providing comprehensive PHC to Aboriginal and Torres Strait Islander people through both non-Indigenous and Indigenous-specific health care services
- the cost effectiveness of specific activities under the IAHP and emerging policy priorities.

The alignment between the economic evaluation, this evaluation and the delivery timeframe is yet to be determined. The first phase of the evaluation was undertaken by Deakin University and completed in mid-2018. It explored the return on investment in terms of avoided hospital costs and compared the relative costs of consultations by ACCHS with mainstream primary care providers.

The next phase of the economic evaluation is under consideration by the DOH. Once the approach is confirmed, the evaluation team will consult with the DOH and the economic evaluation provider(s) about alignment and opportunities for the two studies to inform each other.

**3.4.2. Program and Services Evaluation Framework for Aboriginal and Torres Strait Islander Community Health**

The DOH requires the evaluation design to be consistent with, and have clear line of sight to, the *Program and Services Evaluation Framework for Aboriginal and Torres Strait Islander Community Health* developed by NSW Health. The IAHP evaluation will address the framework’s fundamental questions as described in Table 3.

**Table 3: Alignment of evaluation with NSW Health Program and Services Evaluation Framework**

Questions from the core of the <i>Program and Services Evaluation Framework</i>	Corresponding KEQs and objectives (OBJ) from the IAHP evaluation design	Relevant evaluation sub-questions and further explanation of alignment
Is the program <b>improving</b> health, and enabling Aboriginal and Torres Strait Islander people to <b>take control of</b> their own health?	KEQ: How can faster progress be made towards <b>improving</b> health and wellbeing for Aboriginal and Torres Strait Islander people?	The IAHP evaluation sub-questions explore what is working well, how to <b>share success</b> more broadly, <b>what needs to change</b> at a system level, <b>what action can be taken</b> to address the social and cultural determinants of health and environmental health, and what <b>improvements</b> can occur in the IAHP and broader policy settings.
	KEQ: What difference is the IAHP making towards improving health and wellbeing for Aboriginal and Torres Strait Islander people?	The IAHP evaluation will explore to what extent individual people are <b>enabled to manage their own health</b> , along with how well the IAHP is meeting Aboriginal and Torres Strait Islander people’s <b>holistic view of health</b> , including their social and emotional wellbeing, and the social and cultural determinants of health.
Assessment of <b>priority setting</b> : Was the priority-setting process that led to the funded program <b>appropriate</b> and comprehensive?	KEQ: How well is the IAHP enabling the PHC system to work for Aboriginal and Torres Strait Islander people?  OBJ: The evaluation is to evaluate the <b>appropriateness</b> and effectiveness of the Australian Government’s investment in Aboriginal and Torres Strait Islander PHC.	The IAHP evaluation sub-questions extensively explore issues of <b>reach and unmet need</b> – who is receiving / benefiting from the IAHP, who is missing out, and whether their range of needs are being met. The evaluation is to address the implications for the IAHP and the Implementation Plan of who is missing out on the services and on any unmet need, and also to address issues of policy, investment and practice.

Questions from the core of the <i>Program and Services Evaluation Framework</i>	Corresponding KEQs and objectives (OBJ) from the IAHP evaluation design	Relevant evaluation sub-questions and further explanation of alignment
Evaluation of <b>program development and implementation</b> : Was the program adequately <b>planned</b> and implemented?	KEQ: How well is the IAHP enabling the PHC system to work for Aboriginal and Torres Strait Islander people?	The evaluation will be exploring how the IAHP was <b>planned, delivered and how well it is operating</b> , including in relation to the PHC and wider health systems; the functions it is carrying out; and the services it is delivering and enabling. It will also explore the reasons for and decisions behind each of these aspects. As noted earlier, the DOH has a comprehensive IAHP program logic and theory of change informing the <b>development and implementation</b> of the IAHP.
<b>Effectiveness</b> : Is the program achieving (or has the program achieved) its objectives, with regard to service provision, health improvement and community empowerment?	<i>All four of the IAHP key evaluation questions.</i> OBJ: The evaluation is to evaluate the appropriateness and <b>effectiveness</b> of the Australian Government's investment in Aboriginal and Torres Strait Islander PHC.	Issues of <b>service provision</b> are explored in terms of sub-questions about responsiveness, reach, sustainability, appropriateness and sharing of learning and success. Issues of <b>health improvement</b> are being addressed both in terms of improvements in the PHC system and health and wellbeing outcomes for Aboriginal and Torres Strait Islander people. <b>Community empowerment</b> is explored by the sub-question – to what extent are communities enabled to input into the design of local health service delivery?

Both the framework and the IAHP evaluation are a comprehensive mix of formative, process and outcome evaluations (refer [Glossary](#)). The IAHP evaluation extends the framework's focus from a program level to a whole-of-system level, and emphasises the following factors to increase the impact of the evaluation:<sup>70</sup>

- a *systems* perspective both in the evaluation approach and process, assuming emergence, local adaptation, and non-linearity
- the framing of the evaluation *as a creative, collaborative and active enterprise* with human experience at its core
- the *process of the evaluation* – the nature of relationships, governance and facilitation arrangements, resourcing, style of leadership and how differences are managed.

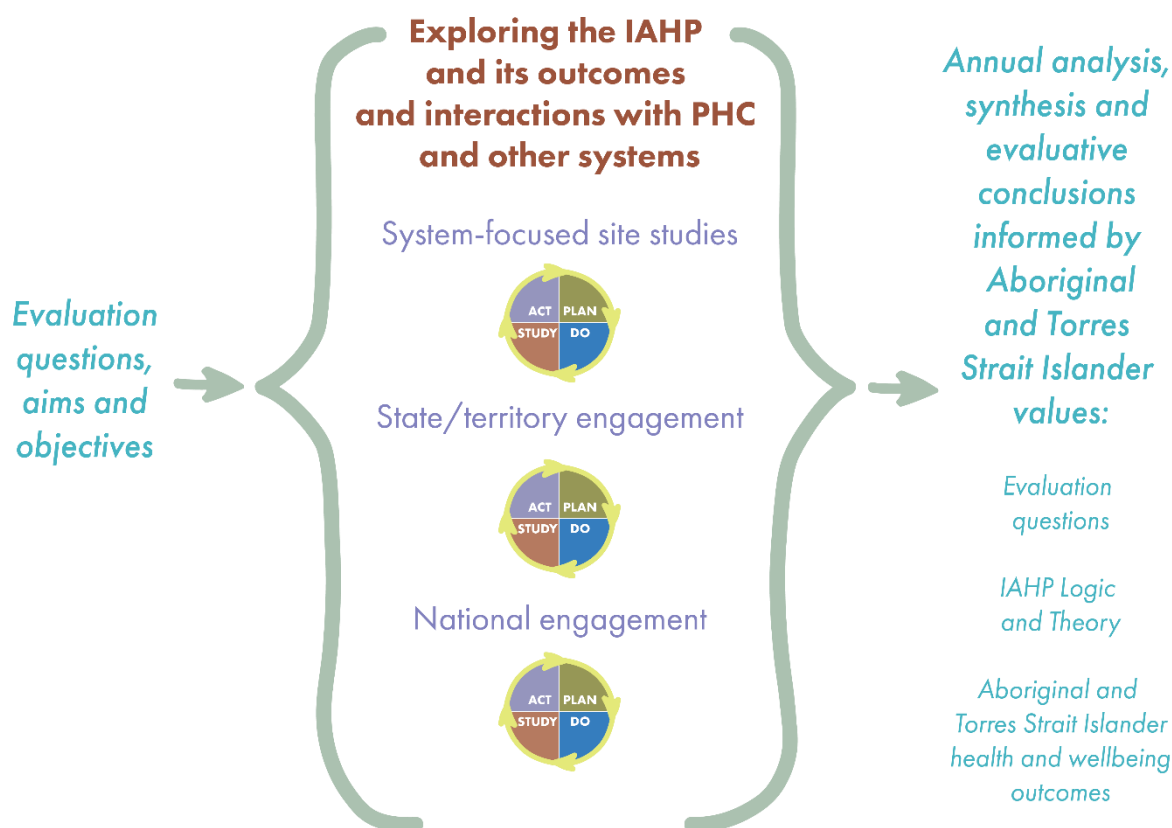


## 4. Methodological design

This section provides an overview of the methodological design and a description of the evaluation approaches informing the design. The section concludes with commentary on the opportunities presented by the evaluation and a discussion of the design limitations.

### 4.1. Overview of the approach for conducting the evaluation

Figure 4: Overview of the evaluation design



The evaluation design illustrated in Figure 4 includes the use of multiple local/regional system-focused site studies, engagement with national and state/territory stakeholders, and bringing various groups of stakeholders together in collaboratives to address the evaluation questions, aims and objectives. The evaluation will utilise a developmental, cyclic process to co-create knowledge and action, enabling system changes and actions in response to the emerging evaluation findings. Overarching analysis, synthesis and evaluative conclusions informed by Aboriginal and Torres Strait Islander values will occur annually,

*There is a need for an ecological (whole of system) and adaptable approach to evaluation that can include any important areas of inquiry that emerge.*



addressing the evaluation questions, testing and building the IAHP logic and theory, and reporting on the difference the IAHP is making, including to the health and wellbeing of Aboriginal and Torres Strait Islander people.

Building capability and resourcing the evaluation appropriately are also key components of the evaluation design. The following sections describe the purpose and rationale for each component of the design specifically:

1. System-focused site studies involving local/regional communities and providers
2. National and state/territory engagement
3. Collaboratives
4. A developmental, cyclic approach
5. Capability building and resourcing.

#### **4.1.1. System-focused site studies**

##### **The use of geographic sites as the primary unit of design and analysis to enable a systems focus**

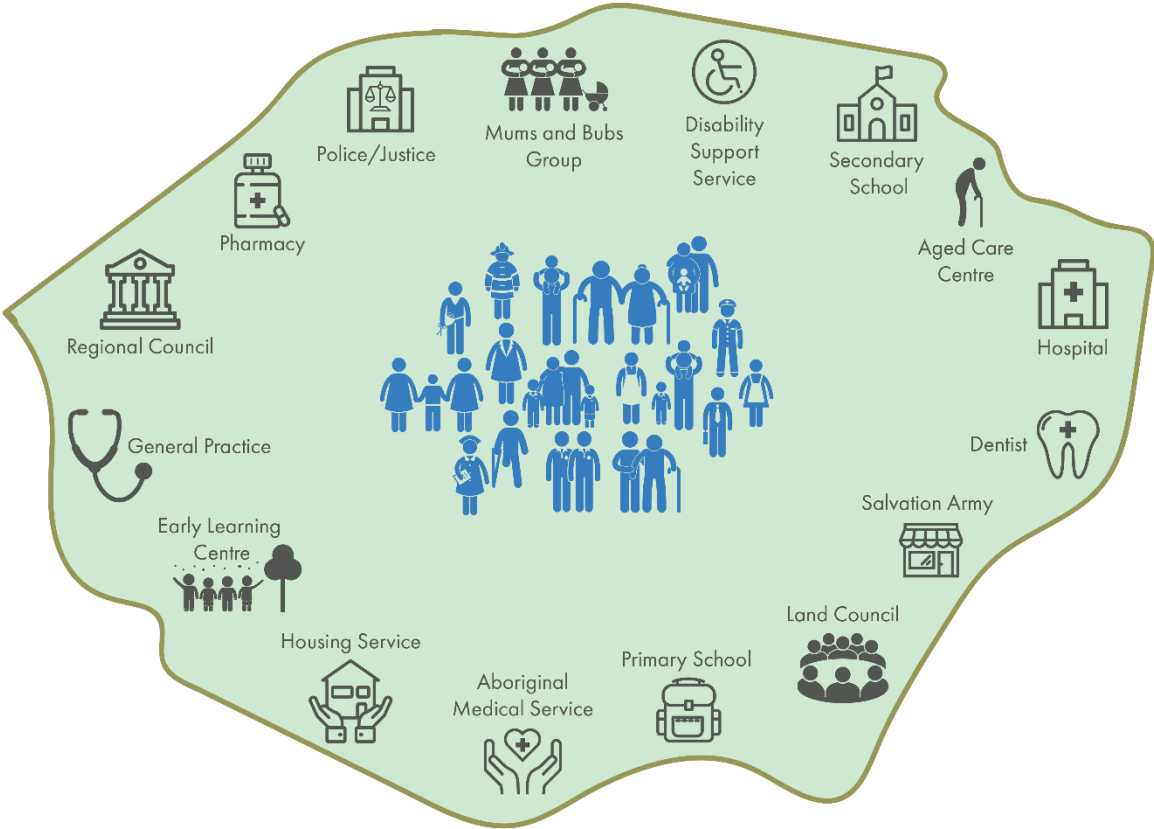
The evaluation needs to answer questions about the IAHP and its interaction with the PHC and other health systems, programs and the social, economic and cultural determinants of health, and about resulting health and wellbeing outcomes for Aboriginal and Torres Strait Islander people. To do this, the evaluation will use geographic 'sites' – places where people live, work, seek and receive (or not) PHC and related services – as the primary unit for design and analysis. The geographic areas will be known in the evaluation as 'system-focused site studies' (referred to as 'sites'). The potential participants in a site study are illustrated in Figure 7 which includes both community members and service providers.

The use of sites will enable a contextualised, in-depth understanding of the complex interactions within and between the communities, PHC, other relevant systems, programs and factors. The sites will be geographic areas large enough to explore the PHC system in operation, to consider trends over time, and to enable comparisons between sites and the rest of Australia. The sites will include a range of PHC providers – Aboriginal Community Controlled Health Services, Aboriginal Medical Services, private general practices and other government and non-government funded services – in a variety of different contexts, as illustrated in Figure 5.

##### **Data**

The system-focused site studies will utilise both qualitative and quantitative data to enable an in-depth analysis of how well the IAHP is enabling the PHC system to work for Aboriginal and Torres Strait Islander people, the inter-relationships and influences with other health systems, programs and determinants, and whether or not the IAHP is having the desired impact. The use of geographic sites and boundaries also enables links to population and other key data needed to answer the evaluation questions. Section 5 describes the data that may be utilised.

**Figure 5: Potential participants in a system-focused site study**



**Site-based co-creation sessions**

Key stakeholders will be invited to come together within sites to analyse and interpret the data (including trends), discuss emerging evaluation issues and findings, and collectively problem solve and identify solutions and actions to improve health service planning, delivery and outcomes. An important part of this analysis and discussion will be exploring and understanding what is occurring and what needs to change at a system level, e.g. assumptions, policies, practices, values, relationships, behaviours and attitudes.

**Two types of sites**

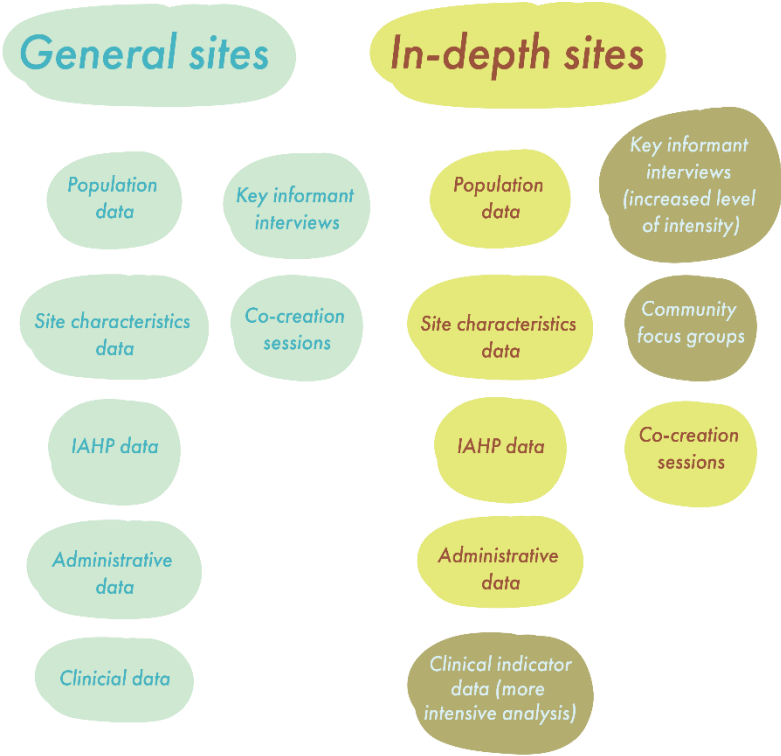
In recognition of the variance in local circumstances that can impact on a site’s capacity to participate in an evaluation, sites will be invited to participate at either a lower level of intensity (referred to as general sites) or a higher level of intensity (referred to as in-depth sites). The difference between the two types of sites is illustrated in Figure 6.

General sites will involve the analysis of population data, site characteristics data, IAHP data, and nationally available clinical data; possibly administrative data, hospitalisations, mortality and morbidity data; and key informant interviews and co-creation sessions. In addition to what will occur with the general sites, in-depth sites will involve more intensive data gathering and analysis,

including additional clinical indicator data, in-depth interviews and community focus groups. Both will involve co-creation sessions that are described below.

The two types of site provide breadth and an ability to generalise findings (including to compare and contrast), as well as enabling an understanding of what works, for whom and in what circumstances (due to the in-depth study).

**Figure 6: Two types of sites**



**Number of sites**

The evaluation team strongly recommends that between 20 to 24 system-focused site studies occur, with half being general studies and the other half in-depth.

This number of site studies will most effectively achieve the dual brief of the evaluation – co-creation of knowledge and action while being realistic in terms of resources and costs. It will also account for variations in PHC service models and models of care, geography, population density and diversity, distinct population groups (particularly hard-to-reach groups), levels of IAHP funding and progress on key indicators.

If there is insufficient budget for between 20 to 24 sites, then between 16 and 19 sites should be selected. Sixteen sites is the minimum number for the evaluation to deliver on its brief, albeit less effectively, and account for most of the variations as described above.

#### 4.1.2. National and state/territory engagement

The DOH, including the IAHP program managers and other national and state/territory stakeholders, will be key informants in the evaluation and participants in the co-creation sessions. These stakeholders will be engaged, as appropriate, in co-creation sessions horizontally – across divisional and departmental boundaries – and, where possible, with others across the health system. The Health Sector Co-design Group is a current example of a national-level, across-system engagement.

##### National engagement

The IAHP program managers and other Indigenous Health Division staff are key informants regarding policy intentions, the operationalisation of the program, and how the components in the IAHP theory of change and program logic are intended to work together. Along with other stakeholders – such as PM&C, NACCHO, workforce bodies and professional associations – they will have key information about the challenges, barriers, enablers, solutions tried to date, and other relevant experience and knowledge. Involvement by the full range of national-level stakeholders is key to identifying and actioning policy-led and other solutions in response to emerging evaluation findings.

##### State/territory engagement

Like national stakeholders, those in the states and territories will be key informants about how well the IAHP and PHC is working in their jurisdiction, what difference the IAHP is making, the success of past and current initiatives, and specific contextual issues. They will be particularly interested in emerging findings from sites in their state/territory, and how these compare with sites in other jurisdictions. Involving a range of state/territory stakeholders is also key to identifying and actioning state/territory-led solutions in response to emerging evaluation findings.

#### 4.1.3. Cross-cutting collaboratives

##### Collaboratives

Alongside the analysis and collective action occurring through a range of stakeholders coming together in co-creation sessions *within* sites, stakeholders from communities, PHC, health and/or other systems will be brought together *across* sites and from other parts of Australia to focus on cross-cutting themes relating to the IAHP. These will be called *collaboratives*.

Collaboratives is a familiar term and concept. It is commonly understood to be a group of people who come together in a co-operative endeavour to question, understand and solve a real problem collectively. Collaboratives addressing clinical and other health issues are already in operation in some places. NACCHO, for example, uses a related concept, that of clusters of ACCHSs – stakeholders with common interests coming together as an effective approach to share learnings and identify new, creative solutions to shared challenges.

In this evaluation, collaboratives will be groups of stakeholders coming together to problem solve and identify actions to address a common issue – a cross-cutting theme. The nature of the issue will determine the composition of the collaborative, which may also include subject experts, as well as the length of time the collaborative will exist. Examples of collaboratives could include:

- Organisations or stakeholders keen to work with other similar organisations or stakeholders to problem solve and identify solutions to an issue facing them all.
- Different organisations or stakeholders that come together to enable a better understanding of an issue from their varying perspectives and experiences, and to identify a range of potential solutions applicable to different parts of the system.
- Sites with similar circumstances, e.g. very remote, urban, brought together to deepen their understanding and problem solve a common issue.

The difference between co-creation sessions and collaboratives is that the former is site-based, and the latter is theme- or issue-based. Both will carry out similar functions – i.e. analyse and interpret data, discuss emerging evaluation findings, and collectively problem solve and identify solutions and actions – and both will be focused on what needs to change across the system.

### **Increasing the potential for doing things differently**

The focus in this evaluation will be, wherever possible, to facilitate trans-system discussions and solutions that recognise system problems and require system solutions. However, we also recognise that, in some circumstances, this might be a stepped process with groups of ‘like’ stakeholders coming together first before engaging with relevant others across the system.

The use of both collaboratives and site-based system-focused studies will enable:

- wider, more in-depth analysis and interpretation of data and emerging issues and findings from the evaluation
- wider sharing of learnings, influencing, cross-fertilising and building capability through the intersection of ‘similar’ and/or ‘different’ stakeholders
- a variety of collaborations that could break through problems and design new and innovative solutions.

### **Number of collaboratives**

The collaboratives will emerge in response to the evaluation findings in Years 2–4 of the evaluation. We propose that the number and length of time the collaboratives exist is fluid, with a maximum of three collaboratives each year. Some of the collaboratives may be a one-off event, whereas others may continue for two or three years.

#### **4.1.4. A developmental, cyclic approach**

Adopting a developmental, cyclic approach is fundamental to ensuring that the evaluation is responsive to evolving evaluation, policy and community needs and issues.

## **Iterative and flexible**

The DOH brief requires the evaluation to provide rapid learning opportunities that will enable stakeholders to act on emerging findings during, as well as at the end of, the evaluation. In turn, the evaluation needs to be able to support and track adaptations and/or new ways of doing things, to explore changing policy contexts and to tailor itself to local needs and conditions.

## **Balancing responsiveness and contractual obligations**

While flexibility and responsiveness are built into the design, the evaluation will continue to be governed by the need to answer the four key evaluation questions and sub-questions. At the beginning of and during each year, reflection and discussion throughout the national and local co-design and co-creation processes will ensure that the evaluation continues to be of significant value and remains focused on maximising the benefit of the evaluation resource.

## **Cyclic**

The cyclic concept is based on a mix of participatory action research and continuous quality improvement cycles to enable rapid reflection, learning and adaptation, and/or the creation of new solutions on a regular basis.

In this evaluation the components of a cycle across all levels – site, national and state/territory – are:

- Plan
  - planning and piloting
  - preparation of quantitative data.
- Do
  - co-creation sessions focused on making meaning of data
  - qualitative fieldwork.
- Study
  - evaluation analysis and reporting
  - co-creation and collaborative sessions focused on knowledge and action.
- Act
  - site, national and state/territory action in response to emerging evaluation findings.

The cycle is illustrated in Figure 7 below.

Timeline

Figure 7: Plan-Do-Study-Act Cycle



The evaluation will take place over four years. It will commence with a co-designed establishment phase, followed by three co-creation and collaborative cycles. The last year will focus on transitioning and sustaining the evaluation activities found to be most valuable, and on producing the final report. What will occur in each of the years is described in detail in Section 7.

4.1.5. Capability building and resourcing

The DOH would like to develop an improved understanding of Aboriginal and Torres Strait Islander people’s values, perspectives and experiences of the health system, as well as those of their health care providers. In addition, the DOH wants to know more about what is occurring through, and being achieved by, the IAHP. Those consulted during the process of designing the evaluation highlighted the need for support with problem solving and facilitating solutions, along with knowing more about how and where government health care funding is spent. Some also noted that effective engagement in the evaluation may need to be resourced, that less intense evaluative processes over the longer term are favoured, and that processes to support systems strengthening must be sustained beyond the term of the evaluation.

In this evaluation, building capability is regarded as a multi-directional activity recognising that everyone brings valuable knowledge, skills, experience and perspectives to any situation. In response, the evaluation design incorporates:

- facilitated forums for stakeholders (co-creation and collaborative sessions) to come and work together to problem solve and identify solutions and action plans
- recent, analysed data and facilitated data making meaning (as part of the co-creation and collaborative sessions) to enable better informed decisions for providers, and for national and state/territory stakeholders
- multiple opportunities across the PHC system, at policy, practice and community levels, for evaluation participants to identify and act on improvements in health service design, delivery and outcomes
- up-to-date horizontal and vertical information flows between participating stakeholders across the PHC system, along with wider communications.

Through these engagements, capability will be built for all participating stakeholders in:

- evaluation and research
- systems analysis
- data interpretation
- co-design and co-creation
- different knowledge and value systems.

The capability building approach and learning is illustrated in Figure 8.

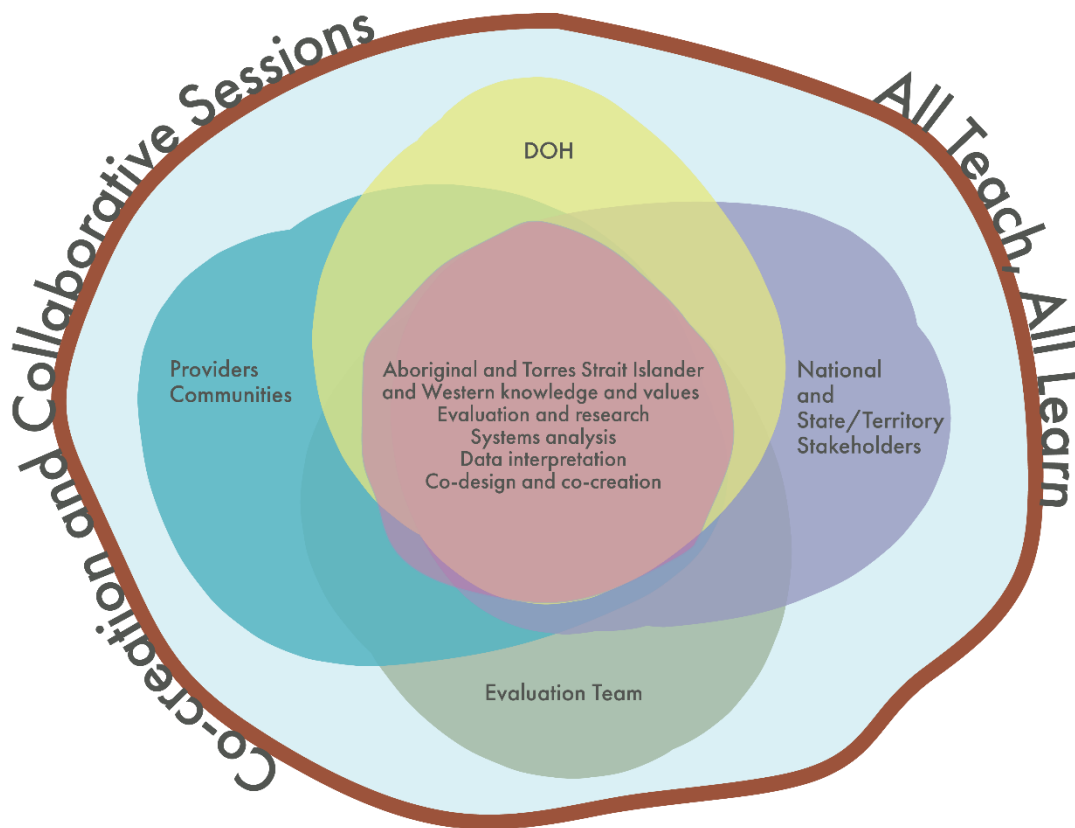
On a practical level, the evaluation needs to be appropriately resourced. Figure 9 shows that the evaluation will provide the following products, people, processes and resources:

#### *Products*

- Prepare the Memorandum of Understanding negotiated with sites and national and state/territory stakeholders.
- Prepare the co-designed, tailored evaluation plans, the service and IAHP maps, and contextual descriptions.
- Provide annual analysed data reports.
- Provide summaries for all co-creation and collaborative sessions.
- Provide annual interim national evaluation reports, including summary reports.



Figure 8: Capability building



#### *People*

- Employ a local evaluation co-ordinator to work on site-based evaluation activities.
- Provide facilitators for the co-creation and collaborative sessions, as well as the services of the evaluation team.

#### *Processes*

- Provide hosting, facilitation and secretariat services for co-creation and collaborative sessions, including travel and accommodation expenses, and a facility to pay community participants in sessions as appropriate.
- Provide thank you vouchers for interviews and focus groups with community participants.

#### *Reciprocity*

- Hold discussions with communities and providers to identify and provide support in areas they would find immediately beneficial.
- Resources for capability building
- Provide training for the locally based evaluation coordinators, along with other evaluation team members, in order to carry out the evaluation activities.

- Create opportunities for locally based evaluation coordinators to participate in relevant conferences and similar professional development and evaluation dissemination activities alongside members of the evaluation team.
- Support the development of evaluation tools for use by communities and providers.

*Resourcing actions*

- Provide some resourcing for implementing actions, such as training or knowledge expertise, where this is not already in place.
- Facilitate linkages with organisations that provide relevant services and/or could provide support and resources.

**Figure 9: Resources**



## 4.2. Methodological approach

There are many evaluation approaches and ways in which an evaluation can be designed. The key to good design is choosing methods that will robustly and transparently answer the evaluation questions, effectively achieve the evaluation aims and objectives, are ethical and respectful of all participants, and credible to a wide range of stakeholders.

This evaluation requires an understanding of how the program is operating, demonstrating the extent to which the desired changes are occurring, and supporting a process for expediting

improvements. It also requires a whole-of-system and deeply contextualised understanding and response, and a highly participatory approach that has Aboriginal and Torres Strait Islander values, perspectives and experiences at its centre.

To do this, there will be explicit processes for working with both Aboriginal and Torres Strait Islander and Western knowledge systems supported by co-design and co-creation approaches. A developmental evaluation approach will be employed that draws on elements of process and impact evaluations (refer [Glossary](#)). These will be underpinned by systems thinking, evaluation-specific logic, program theory, continuous quality improvement, participatory methods, and realist and theory-driven evaluation.

The following sections briefly describe the blending of these approaches and their application.

### **Working with Indigenous and Western knowledge**

Throughout the evaluation, we will actively continue to balance both Aboriginal and Torres Strait Islander and Western knowledge, processes and ways of knowing and being – recognising that both systems are not homogenous. Western knowledge and worldviews are well represented; the evaluation is being carried out for the DOH, a Western institution, has been designed by a mainstream evaluation consultancy and draws on a number Western methodologies and approaches.

Aboriginal and Torres Strait Islander knowledge and worldviews will be embedded throughout the evaluation via the involvement of senior Aboriginal experts in evaluation roles, governance, technical support and all aspects of the evaluation process, including:

- negotiating agreement and respecting ownership of data and information
- working in partnership with Aboriginal and Torres Strait Islander people to interpret and reach culturally valid conclusions
- ensuring sufficient time for relational and appropriate processes to occur
- supporting self-determination.

The evaluation will utilise participatory and community-based evaluation and research methods, which can be powerful in bringing about change and benefit for Indigenous communities. A challenge for the evaluation is to:

*move beyond the rhetoric of participatory research [and evaluation] towards a model of research [and evaluation] in which Indigenous knowledge, processes and ways of knowing are respected and – as much as is possible – understood, felt, and acknowledged through relational ethical frameworks, appropriate epistemology, and negotiated agreements.<sup>71</sup>*

With all the methodological approaches and methods we use, care needs to be taken that we are addressing and not further entrenching inequities. It is not evaluation and research approaches in and of themselves that contribute to better outcomes for Indigenous peoples; rather, it is the application of principles and practices that consciously address issues of inequity in power, the need for diversity of voices, values and knowledge, and the benefits that will arise from the evaluation itself.

## Co-design and co-creation

Co-design and co-creation are understood and applied in a variety of ways. For the purposes of this evaluation, co-design is defined as the active involvement of stakeholders at national, regional and local levels, whose perspectives will collectively inform and shape the ongoing iterations of the evaluation over the four years of its implementation. Co-creation is defined as the collective creation of knowledge and understanding, and of solutions, responses and actions to address issues.

Simply put, co-design is focused on the implementation of the evaluation, and co-creation is focused on addressing the findings emerging throughout the evaluation. Both co-design and co-creation are focused on developing innovative solutions through participatory, collaborative processes.

With both processes we need to be clear, transparent and honest about how we are applying the 'co' – both who the 'co' is and the nature of our engagement with people. We need to be clear whether it is led by the participants, or whether it is led by a collaborative, consultative or informing type-process. We also need to be clear as to who has control over decisions and resources.

A number of Aboriginal or Torres Strait Islander people have identified that the 'co' in co-design means working under Aboriginal and Torres Strait Islander leadership, having access to the same information, and working together to identify the problem. Co-designing the problem(s) that initiatives are being, or have been, developed to address, is key to co-designing the solution(s), otherwise different conceptualisations of the problem will most likely result in disparate solutions. As described earlier, the 'design' in 'co-design' in Aboriginal and Torres Strait Islander contexts means it is more than tools – it is a relational and empowering process that is tailored to contexts and involves the co-creation of ideas.

Indigenous leadership in this evaluation occurs at a number of levels:

- There is Indigenous leadership at the evaluation commissioning organisation (the DOH), within the governance arrangements for the evaluation (refer Section 7.3), and in the evaluation team itself.
- Leadership and facilitation of the evaluation co-design and co-creation sessions will either be Aboriginal and/or Torres Strait Islander led or co-led with non-Indigenous members of the evaluation team.

The prefix 'co' – co-habitation and co-operatives – is well known within Aboriginal and Torres Strait Islander communities. Aboriginal and Torres Strait Islander researchers have long been practising participatory and community-based ways of working, that are often associated with co-design, to give effect to self-determination and empowerment. Some are also working with an Indigenous form of design – respectful design – when conducting social and

*The 'co' in co-design translates to Aboriginal and Torres Strait Islander leadership, a genuine understanding of context and worldviews, acknowledging any limitations in understanding, trust, respect, transparency, sharing, and working from a strengths-base.*

emotional wellbeing projects, as this approach has a strong fit with the narrative and visual aspects of Aboriginal and Torres Strait Islander cultures.<sup>72</sup> The co-design and co-creation sessions are all workshop-based, which will enable people to participate using narrative (e.g. stories) and visual methods. Both written and visual methods of reporting ideas and concepts will be used in the evaluation.

In Western literature, co-design involves a particular ‘way of thinking’ – design thinking. Design thinking is solution focused as it starts with the goal of a better future rather than a problem to solve. It is also a creative process in that it builds up rather than breaks down ideas, emphasises synthesis rather than analytical thinking, and employs both divergent and convergent thinking. Design thinking is iterative, non-linear, can be simultaneous and repeated, and allows the process of learning to influence the design rather than specifying everything upfront.<sup>73,74,75</sup> The evaluation will employ design thinking in the co-design and co-creation sessions described in Section 4.1 The structure of the evaluation design enables iterative learning processes to inform the pathway of the evaluation over the four years within the framework of evaluation questions, aims and objectives.

### **Process evaluation**

KEQ 1 – How well is the IAHP enabling the PHC system to work for Aboriginal and Torres Strait Islander people? – is a process evaluation question. Answering it will require understanding how the IAHP was planned, delivered and how well it is operating, including in relation to:

- the PHC and wider health systems
- the functions it is carrying out
- the services it is delivering and enabling
- who is receiving the services and who is missing out
- whether it is meeting the range of needs.

It will also need to include the reasons for, and decisions behind, each of these aspects.

### **Impact evaluation**

KEQs 2 and 3 – What difference is the IAHP making to the PHC system, and what difference is the IAHP making towards improving health and wellbeing for Aboriginal and Torres Strait Islander people? – are impact evaluation questions. Answering them will require identifying the range of changes to which the IAHP is contributing, changes in the PHC system, and changes in Aboriginal and Torres Strait Islander health and wellbeing. Section 5 describes the potential data sources and their application to answering these questions.

## Developmental evaluation

KEQ 4 – How can faster progress be made towards improving health and wellbeing for Aboriginal and Torres Strait Islander people? – is normally a formative evaluation question focused on identifying and recommending improvements, often in the early stages of program implementation. However, this evaluation requires demonstrable improvements in health and wellbeing to occur **during** the evaluation in an environment where the IAHP has a complex interaction with the PHC and other health systems and programs, and with the social, economic and cultural determinants of health.

Developmental evaluation brings in systems thinking to guide innovation and adaptive management in complex environments. We will draw on core concepts from across the systems field, such as understanding inter-relationships, engaging with multiple perspectives and reflecting on boundary decisions to help address problems.<sup>76</sup> We will also utilise specific health system frameworks to gain a better understanding of the dynamics within the system (briefly described in Appendix 4).

Developmental evaluation utilises a mix of typical and real-time evaluation processes in a collaborative, long-term relationship with a strong focus on utilisation.<sup>77</sup> The ‘real-time’ processes employed by this evaluation are described in Section 4.1. These are informed by continuous quality improvement and participatory action research. The ‘typical’ evaluation processes we will be using are process and impact evaluations, briefly described above, and evaluation-specific logic (see below).

## Theory-driven evaluation

The evaluation will be informed by, build, test and refine, the DOH’s comprehensive *program theory* which includes a logic model and theory of change (refer Appendix 5). We propose a theory-building and testing approach given the relationships and mechanisms of change are not always apparent in the current model, and there are aspects of the systems that are more evidence-based whereas others are in a more developmental stage.

*Realist evaluation*, a form of theory-driven evaluation, will be employed as an analytical approach to provide insight into the interaction between contextual influences and mechanisms by which the IAHP operates (refer Section 6). Realist evaluation also provides for testing theories and hypothesis in interviews and discussions with evaluation participants.<sup>78</sup>

The current program theory will be used to inform the development of success criteria and indicators for tracking change as part of developing the detailed plan for answering the evaluation questions early on in Year 1.

## Evaluation-specific logic

It is important to be clear that the purpose of undertaking an evaluation is to go beyond describing what, how and why something is happening, and to arrive at explicit conclusions about how good, valuable or important something is. All four key evaluations questions require identifying the *values* (criteria) by which assessments will be made about:

- what ‘working well’ looks like, for whom, and in what contexts

- whether the ‘difference’ and ‘amount of difference’ that is occurring is worthwhile
- what the ‘best ways’ are of making faster progress.

This will require systematic, transparent processes for blending quantitative and qualitative data together with the relevant values for drawing robust, credible conclusions. Determining the ‘relevant’ values will also require making explicit both Aboriginal and Torres Strait Islander and Western worldviews and perspectives. This will occur through identifying what is important to evaluation participants and participatory processes for blending different types of data, interpreting and making meaning, and drawing evaluative conclusions.

### **4.3. Opportunities**

Although focused on the IAHP, the greatest opportunity presented by this evaluation is a chance for the Government and the evaluation team to engage in a sustained partnership with Aboriginal and Torres Strait Islander leaders, health care providers, communities and other stakeholders in a participatory and effective process to achieve tangible and positive change. Aboriginal and Torres Strait Islander people are at the centre of the evaluation, and there is a commitment to maintain this orientation and focus. An evaluation of this scale and design, allows issues to be explored in some depth, and with a wide range of Aboriginal and Torres Strait Islander people.

Positive work and innovation can be recognised and highlighted. Feedback processes and a co-creation approach provide opportunities for genuine insights and a better understanding of how contextual factors may affect both outcomes and individuals. The opportunities for ongoing co-design and flexibility to explore questions in different communities, geographical or communities of interest, allows genuine benefit to occur from the different perspectives and capability of diverse Indigenous communities.

This evaluation provides an important opportunity to determine how IAHP investment in different interventions and models of primary care influences health equity and Indigenous health outcomes. The opportunity to explore the influence of the IAHP on the wider health system has the potential to identify unintended effects and to engage the resources of ‘mainstream services’ more effectively in accelerating progress towards the CtG targets.

By providing robust evidence to inform the development of policy and future primary care delivery, and through the quality improvement generated at sites, the evaluation has the potential to contribute to accelerated improvements in health outcomes.

There will be gains in knowledge, insights and understanding for participants at all levels, as well as gains in skill and expertise for the evaluation team, providers, staff at state/territory and federal government levels, and partners in academic institutions.

### **4.4. Limitations**

The opportunities are balanced by many practical factors including the scope and parameters in the Government’s evaluation brief, further refined through the co-design process. There is a need for consistency across some elements of the methodological design and data to provide useful information, and limitations related to feasibility, resources and time constraints.



The interest, capacity (given many competing demands and pressures) and resources of providers and communities will influence participation, data collection, interpretation and the depth of engagement. Providers struggling with less capacity, communities with fewer resources and those with the highest unmet need may well be the least able to participate. Although some measures have been built into the evaluation design and budget to address this limitation, there will likely be better participation, data collection and information from sites and communities with more capacity, cohesion and stronger links to government.

The cultural competence of evaluators, their ability to gain trust and many of the relational aspects of the evaluation over four years will enhance or limit information shared, and the power of planned 'sense-making' processes. The time, skills and resources needed for respectful and productive engagement is balanced against the desire to cover a wide range of sites and contexts. The evaluation design attempts to address this through the size of the sites, the mix of general and 'in-depth' sites, the voluntary nature of participation, the skill mix of the current and planned evaluation team, and the planned approach that is phased, respectful and iterative.

There are well-recognised data limitations in the Australian health system and PHC practice management systems that have been documented both in this report and elsewhere. There is no way to identify with a high degree of accuracy the number of MBS services or PBS-funded items delivered to Indigenous people, and trend data will be the result of multiple influences. The caveats around data will be made explicit.

Complexity creates its own limitations. While the methods and approach are designed to explore contextual factors, the ability to capture, understand and describe the complex interactions between 'data', historical and contemporary factors, cultural dimensions, social determinants and intangible aspects affecting health is difficult. Thus, despite best efforts, there will be limitations.

Finally, although the evaluation is designed to maintain a co-design and co-creation culture, to facilitate adaptive management and to support continuous improvement locally, some factors will be outside the control of evaluation participants. Decisions around the IAHP elements, the funding model and other features of the program re-design may be informed by the evaluation but will ultimately be made at departmental and ministerial levels.





## 5. Data sources

This section outlines the approach to, and an overview of, the use of data in this evaluation, followed by a discussion of the data sources that will be and could be used to address the evaluation questions, aims and objectives.

### 5.1. Approach and overview

#### 5.1.1. Approach

Determining the specific data and data sources, analyses and reporting that are most appropriate to answer the evaluation questions, and address the aims and objectives of the evaluation, is a key co-design task in Year 1. A feasibility analysis of the quantitative data sources described in this section will be undertaken, along with the development of a detailed plan for answering the range of evaluation questions and exploring the IAHP logic and theory. The feasibility analysis and plan for answering the evaluation questions will be developed by the evaluation team in consultation with the DOH and the HSCG. They will both inform and be informed by the selection of the sites for the system-focused studies.

A monitoring program will be put in place post the feasibility analysis and the development of the plan for answering the evaluation questions in Year 1. The monitoring program will include three components:

- a baseline quantitative data report followed by a range of annual reports as described in Section 4.1
- tracking the learnings and changes resulting from the evaluation process
- tracking the actions undertaken by participants as a result of the co-creation and collaborative sessions.

The approach to data and monitoring in this evaluation design is somewhat different from traditional designs in which the data that will be used to monitor and answer questions is often specified upfront. One of the purposes of this evaluation is to support both the continuous improvement of the IAHP and the ability of PHC providers and others to improve and adapt their services. Access to, and the ability to understand and make meaningful interpretations of, data is key to making quality decisions about improvements. Therefore, the approach adopted by the evaluation team is one-step back – that is, working with the evaluation participants as part of the co-design and co-creation processes, starting with what data exists and whether it is accessible, identifying what it is possible to use the data for, its limitations and how it could be improved.

As such, the feasibility analysis will address questions particularly about the accessibility and appropriateness of the administrative data for the evaluation, and the quality of and challenges in interpreting clinical data, e.g. hospitalisations, mortality and morbidity data. Rather than make decisions at this point, the evaluation team considers it is important to explore the issues fully with the appropriate evaluation participants and provide a rationale for why data is included or excluded, as part of the evaluation implementation process.

Table 4 lists the data products that will be developed in Year 1.

**Table 4: Year 1 data products**

Name	Description
<b>Quantitative data feasibility analysis</b>	Analysis of the potential quantitative data sources outlined in this section, identification of the data that will and will not be used and the rationale
<b>Plan for answering the evaluation questions</b>	Identification of the qualitative and quantitative data sources and methods that will be used to answer the questions, including the range of criteria to be tested with evaluation participants for making evaluative judgements
<b>Integrated data management protocol</b>	Specification of the administrative and IAHP data requirements and specific suggestions for structure of data extraction for use by the DOH; clinical indicator specification and extraction tools
<b>Evaluation tools</b>	Outline of interview guides, community focus group guides, and co-creation and collaborative analytical/reflection tools developed to address the evaluation questions, aims and objectives

**5.1.2. Overview**

The in-depth sites will involve relatively more intensive data collection and analysis processes. The qualitative data collection methods will include semi-structured interviews with a range of key informants and focus groups with community members. The general sites will have a less intense level of data collection – semi-structured interviews will be conducted with a smaller range of key informants only.

Population data, site characteristics data, IAHP data, and nationally available clinical data **will be**, and administrative data and hospitalisations, mortality and morbidity data **may be** collected and analysed for all sites. The use of additional clinical indicator data will be discussed with all health services across the in-depth sites, within the geographical boundaries of the site. Sites will be provided with an initial baseline quantitative data analysis followed by annual updates.

Analyses of the quantitative data will be undertaken and reported at the different levels as follows, along with relevant comparative analyses to explore factors that can help to explain similarities and differences:

- the general site data reports will include analyses of data available nationally
- the in-depth sites will include analysis of data available nationally and relevant additional clinical data
- state/territory data reports will include an analysis of site data for their state/territory, data for all sites for all of Australia, and data for all Australia
- national data reports will include an analysis of all the site data and the data for the rest of Australia.

These will be reported back and discussed with the sites, national and state/territory participants as part of the making meaning component of the co-creation sessions. The analysis and reporting of data relevant to cross-cutting themes being addressed by the collaboratives will also be undertaken by the evaluation team.

Data confidentiality and anonymity will be addressed. All identifiable data will be de-identified and presented at a site level; it will not be reported at the individual person level or at the health provider level. The analytical and reporting processes will focus on sites, across types of sites, across Australia and system-level analyses (e.g. different types of PHC practice models).

## **5.2. Data sources and their relevance for the evaluation**

These sources were identified through an initial consultative process with the DOH, HSCG and a review by the evaluation team. As described above, the feasibility analysis will address questions particularly about the accessibility and appropriateness of the administrative data for the evaluation, and the quality of and challenges in interpreting hospitalisation, mortality and morbidity data, as part of the implementation of the evaluation. The feasibility analysis will also identify the most appropriate way to source the data – directly from sites as described in the following sections, or from the DOH.

Since the initial consultation with the DOH, two new developments have occurred, including a review of the nKPI and Online Services Report data (due December 2018), and a data mapping project HEADDS Up (possibly available December 2018). HEADDS Up is a mainstream health workforce mapping tool that will incorporate Aboriginal and Torres Strait Islander health needs, workforce capacity and service capability. The implications and possibilities of these will also be explored as part of the quantitative data feasibility analysis.

### **5.2.1. Population and remoteness classification data**

The evaluation requires comparisons between sites over time. To make these comparisons meaningful we need to take into account variations in the number of Aboriginal and Torres Strait Islander people living in the area. The sites need to be defined by both their geographic boundaries and classifications to link to population data.

The remoteness area classification we will use for the evaluation is the Australian Standard Geographical Classification – Remoteness Areas (ASGC–RA). Developed by the Australian Bureau of Statistics (ABS) it gives a statistical geography structure that is suitable for categorising the sites according to remoteness. The five ASGC–RA categories (major city, inner regional, outer regional, remote and very remote) will be reclassified into three categories for the purposes of the IAHP evaluation (urban, regional and remote).

Population data will be obtained from the latest available ABS Census data. It will be used to analyse the administrative data and service provision in relation to potential or actual numbers of Aboriginal and Torres Strait Islander people living within site boundaries.

### **5.2.2. Site characteristics**

For each site we will collect and collate information about the site. This will include data such as population numbers, including the proportion of Aboriginal and Torres Strait Islander people and

age structures, available services and service characteristics, socio-economic characteristics of the population, and characteristics of the specific urban, regional, remote locations in terms of variables such as service centres and transport.

### **5.2.3. IAHP data**

IAHP data (also referred to as program data) are to be provided by the DOH and will be based on reports by the organisations providing services relevant to the IAHP, internal departmental reporting, and existing relevant evaluations. Where appropriate, we will also draw on publicly available information to expand the implementation descriptions. Interviews with key stakeholder organisations will assist in extending the accuracy and completeness of the IAHP data provided. Where necessary, additional collection of program administrative data may occur at a local level within some sites. It is expected that IAHP data will be provided to the evaluation team by the DOH prior to site visits.

Once we have the site boundaries we will work with the DOH to identify which data can be extracted from their reports, and data sources that will address the specific questions for the evaluation. Negotiations in the next phase of evaluation implementation will include discussions with the DOH about timeframes and data specifications. It is acknowledged that program reporting will not necessarily be available at the site level for a variety of reasons, including privacy and level of data extraction. Thus, the data available to the IAHP may not strictly map to the sites' boundaries, and our analysis will need to take into account any such differences.

### **5.2.4. Administrative data**

The Medicare Benefit Schedule, Pharmaceutical Benefits Scheme Co-payment data, and Practice Incentive Program data are proposed to be collected and tracked over time. These data are mostly relevant to questions about access to, utilisation of, or delivery of specific MBS- and PBS-funded items of care, both for Aboriginal and Torres Strait Islander people and the general population. They provide important insights into how the MBS and the PBS is meeting the needs of Aboriginal and Torres Strait Islander Australians, and issues of equity or gaps between them and the general population.

Data are to be extracted from the relevant Medicare, PIP and PBS databases by the DOH, utilising specifications developed by the evaluation team in consultation with the DOH. The defining of the site boundaries will be an important step in developing the specifications for the administrative data, and will be included in the data specifications as a deliverable in the establishment phase of the evaluation.

It is expected that the administrative data will be provided by the DOH to the evaluation team at least three months prior to the annual site visits. In consultation with the DOH, we will establish a 'baseline' period to establish long terms trends. This will be a period that precedes the introduction of the IAHP to allow for an assessment of levels and trends prior to the consolidation of existing programs and funding streams into the IAHP. All administrative data will be de-identified and presented at a site level, not at the individual person level or at the health service level. The analysis will focus on trends over time, rather than a simple pre-post comparison, so as to inform the development of the program more comprehensively.

## Medicare Benefits Schedule data

Medicare items specified for the evaluation will need to be determined in terms of how Aboriginal and Torres Strait Islander status is recorded. Data proposed to be included are: a) Aboriginal and Torres Strait Islander-specific items; and b) General items. General items are for all Australians and we will seek to use the Voluntary Indigenous Identifier (VII) to extract general MBS items to identify uptake by Aboriginal and Torres Strait Islander patients. Although there has been an increase in the use of the VII over time by Aboriginal and Torres Strait Islander people, an assessment of suitability will be required and undertaken in the establishment phase. Consideration will be given as to whether the general MBS items could come directly from the evaluation sites.

MBS items to be extracted by age (0–4; 5–14; 15–24; 25–54; 55+), gender and by the area in which the service was provided; and by sites, and by the rest of Australia classified by state and rurality.

Aboriginal and Torres Strait Islander-specific items to be included are:

- Health assessment for Aboriginal and Torres Strait Islander people (MBS items 704, 706, 708, 710 to 1 May 2010 and thereafter 715)
- Follow-up allied health services for Aboriginal and Torres Strait Islander people (MBS items 81300–81360)
- Follow-up health services provided by a practice nurse or registered Aboriginal Health Worker (MBS item 10987).

Examples of general items to be considered for extraction if VII available include:

- Chronic Disease General Practice Management Plans (MBS 721) and Team Care Arrangements (MBS 723)
- Reviews of the General Practice Management Plans and Team Care Arrangements (MBS 732)
- Consultations – standard, long, prolonged (MBS items 23, 36 and 44 respectively) and home visits (MBS Items 4,24,37,47)
- Antenatal consultation (MBS 16500)
- Telehealth (MBS items 2100, 2126, 2143, 2195)
- Immunisation
- Mental health plans.

It is proposed to collect data on claiming by providers for the Aboriginal and Torres Strait Islander-specific items so as to track trends in the number of items claimed per provider and in the number of claims per provider. This will be done at a site level and for the rest of Australia.

## PBS Co-payment data

The PBS Co-payment was introduced in July 2010, and our analysis will track trends over time in the uptake of this measure. PBS Co-payment data proposed to be used include:

- the number of people accessing PBS Co-payment prescriptions
- the concessional status of people accessing PBS Co-payment prescriptions
- PBS Co-payment prescriptions by Anatomical Therapeutic Chemical.

Data will be extracted by concessional status, age (0–4; 5–14; 15–24; 25–54; 55+), by sites and by the rest of Australia classified by state and ASGC–RA remoteness. The Anatomical Therapeutic Chemical, a global World Health Organization standard for classifying medical substances, allows international comparisons for utilisation statistics in various settings and at different levels.

We will explore with the DOH if we are able to extract data based on the service type (i.e. ACCHS, AMS or General Practice) of the prescriber using PBS data, but we understand that this is currently not possible.

Some of the IAHP sites will be in remote locations and will fall under the special provisions of Section 100 of the *National Health Act 1953*. This allows clients of approved remote area Aboriginal Medical Services to receive PBS medicines directly from the AMS at the time of medical consultation, without the need for a normal prescription form and without charge. Further consultation with the DOH will be required in the establishment phase of the evaluation to access the feasibility and viability of provision of S100 data.

### **PIP–Indigenous Health Incentive data**

The PIP–Indigenous Health Incentive (IHI) was introduced in May 2010. It is proposed to collect data on the PIP–IHI, which has three components: Sign-on payments; Patient registration payment; and Outcomes payments. The data will refer to the number of:

- registered health services
- registered and re-registered patients
- patients registered in the current year
- Tier 1 payments
- Tier 2 payments
- patients who received Tier 1 and Tier 2 payments
- patients registered for PIP–IHI and PBS Co-payment.

Data to be extracted by health service type, rurality, by site and by the rest of Australia.

### **5.2.5. Hospitalisation data**

The purpose of the collection and collation of hospitalisation data is to provide an indication of the IAHP’s impact on clinical outcomes for Aboriginal and Torres Strait Islander people. During the co-design establishment phase of the evaluation (Year 1), we will assess the feasibility of utilising hospitalisation data at a site level. This will depend to some degree on the site specifications, for example, whether it is feasible to extract meaningful data at a site level. Possible data available include:

- all cause hospitalisations

- potentially preventable hospitalisations
- hospitalisations by principal diagnosis (pregnancy, diseases of circulatory system, mental and behavioural disorders)
- smoking attributable hospitalisations
- alcohol attributable hospitalisations
- age-specific diabetes and cardiovascular separations
- low birthweight
- smoking in pregnancy.

### 5.2.6. Mortality and morbidity data

During the co-design establishment phase we will determine the feasibility, value and rationale for the collection and analysis of mortality and morbidity data at a site level in relation to the evaluation questions, aims and objectives.

### 5.2.7. Clinical indicator data

The purpose of collecting and analysing clinical indicator data for the evaluation is to provide an indication of the IAHP's impact on the clinical performance of PHC services located in the sites and, in turn, on the clinical outcomes among Aboriginal and Torres Strait Islander people attending these services. For the purpose of the IAHP we will establish a set of priority clinical indicators that are considered to be of the highest value and relevance, are also widely available from existing clinical information systems and reports, and for which there are reasonably consistent definitions.

During the establishment phase we will explore the feasibility of using clinical indicator and service data extracted from clinical information systems at health service sites, and also map existing data availability through reporting such as the National Key Performance Indicators (nKPIs) and Online Services Report. We will also explore the feasibility of using historical time series data from private general practice that was collected through the Bettering the Evaluation and Care of Health (BEACH) program (while data collection ceased in 2016, it holds 18 years of historical data).

From May 2019, PHNs will be supporting health services participating in the new PIP Quality Improvement Incentive. As this initiative rolls out we will explore the feasibility of utilising data provided to PHNs by participating health services, either by negotiating with the health services directly or with the PHN.

*Data tells one story – narratives on people's experiences and aspirations are also needed.*

### 5.2.8. Qualitative data

Key informant interviews will be conducted to gain insight into stakeholder awareness and perceptions of issues relevant



to the IAHP, a site, and national and state/territory levels. The interviews will be semi-structured and, in the in-depth sites, will include people who use and do not use primary health services.

Community focus groups will also be convened in the in-depth sites to gather information on community awareness and perceptions of health system functioning, and on if and how the IAHP is contributing to change in, and improvements to, the health system at a local level. We will aim to hold two to three focus groups in each of the in-depth sites, during each evaluation cycle.

Along with gathering individual and community experiences, we will also explore the applicability of using patient experience data such as Patient Reported Measures, a mechanism for collecting information from patients on their experiences (PREMs – Patient Reported Experience Measures) and health-related outcomes (PROMs – Patient Reported Outcome Measures). We also need to gather information from people not using services and garner community perspectives on why they aren't.

### **5.2.9. Other evaluation, research and insights**

Appendix 7 lists the range of evaluations and other relevant activities that have been or are planned regarding the IAHP. This information will be drawn on as relevant to answering the evaluation questions, aims and objectives.

There is also a wealth of existing research literature on Aboriginal and Torres Strait Islander people's health and related factors, their health experiences and perspectives, and solutions proposed or developed by a range of stakeholders. This information will also be drawn on to explore and understand emerging findings in more detail and to inform proposed actions.

The co-creation and collaborative sessions in which stakeholders will be making meaning of data, sharing their knowledge, reflecting and developing new insights and understandings will also provide a rich and evolving source of data.





## 6. Analysis and reporting

This section discusses processes for analysing the data and reporting on the evaluation.

### 6.1. Data analysis and integration

Analysis of the data gathered during the evaluation period will be specifically designed to address the evaluation questions, aims and objectives, as well as to test and refine the IAHP theory of change and program logic. The answers will progressively emerge over each year and be documented in the annual interim national evaluation reports, which will build into the final evaluation report.

The analysis of the quantitative and qualitative data will occur through three primary mechanisms that will progressively inform each other:

- production of annual quantitative data
- co-creation and collaborative sessions
- evaluation team analytical processes and reflection sessions.

The co-creation and collaborative sessions will utilise data analysis strategies for working with groups such as the **what** (findings), **so what** (meaning and significance), **now what** (recommendations, actions) framing, patterning via areas of convergence and divergence, and exploring puzzles and surprises. Data analysis will include the use of triangulation whereby patterns of convergence and divergence in the data are identified by comparing results between different sources of data.

The contribution of the IAHP to desired outcomes will be assessed via a range of strategies, for example:<sup>79</sup>

- asking observers
- checking whether the activities of the IAHP match the outcomes
- exploring other explanations
- checking that the timing makes sense
- seeing whether the ‘dose’ is in proportion to the ‘response’
- making comparisons
- using statistical analyses
- identifying and checking the presence of underlying causal mechanisms.

Quantitative data will be examined at a site level, and for the rest of Australia (extracting the sites data). We will examine the data by the rest of Australia to determine how well the data from the

sites reflect what is happening in other parts of Australia, and to gauge if the IAHP evaluation sites are benefitting from the evaluation as an intervention in itself. To understand variations in trends in administrative data by each site, we will undertake an analysis of the contextual variables (examples: average ranking of socio-economic advantage/disadvantage based on the Indigenous Relative Socioeconomic Outcomes Index; percentage of solo practices; general practitioner: population ratios) and the service variables of MBS, PIP and PBS data.

We will draw on the realist evaluation approach to provide insight into the interaction between contextual influences and mechanisms by which the IAHP operates. Realist evaluation aims to elicit 'mechanisms' by which a program achieves its intended outcomes and describes the 'contexts' in which these mechanisms are activated. The context-mechanism-outcomes configurations will be developed iteratively through an analysis of the evaluation data and through the co-creation and collaborative sessions to explain how, when and why a program does or does not work. 'For whom' is considered part of the context.

The validity, and the cultural validity, of the emerging evaluation findings and conclusions will be constantly assessed through the involvement of Aboriginal and Torres Strait Islander people and other key stakeholders throughout all stages of the evaluation, the co-creation and collaborative sessions, the HSCG and CCG sessions, and the use of a Technical Reference Group (refer Section 7.3.5).

## **6.2. Drawing evaluative conclusions**

The criteria on which evaluative judgements will be made will be scoped and discussed as part of the co-designed evaluation planning processes undertaken with the sites, state/territory and national participants in Year 1. This discussion will build on feedback from Phase 1 about the values the evaluation needs to consider in judging the success of the IAHP (see Appendix 3). The criteria will be included in the plan for answering the evaluation questions (see Section 5.1). Criteria will continue to emerge and be documented and discussed throughout the evaluation in the co-creation and collaborative sessions.

The selection of the criteria will be an important, continuous negotiated process throughout the evaluation. There will be a range of applicable criteria, depending on the areas being addressed by the evaluation questions, and different frameworks or perspectives that could be applied, including the diverse worldviews of Aboriginal and Torres Strait Islander and non-Indigenous Australians. The cultural view of health by, and values of, Aboriginal and Torres Strait Islander people will be central to informing the selection of the criteria.

## **6.3. Reporting**

### **6.3.1. Supporting continuous improvement and adaptation**

Along with the co-creation and collaborative sessions, the evaluation will support the continuous improvement and adaptation of the IAHP and PHC service planning and delivery through the provision of regular, timely reporting. The timelines for the reporting are:

- The tailored evaluation plans, services and contextual description will be completed following the establishment of an MOU by the end of Year 1.
- The quantitative data reports will be provided as part of the site visits, state/territory and national engagements and collaborative sessions, which occur over Years 2–4.
- The co-creation and collaborative summaries will closely follow each of these sessions and will be provided to the session participants. They may also be shared with the DOH according to agreed protocols.
- The site selection report to DOH will be provided in March 2019.
- The progress reports to DOH will occur in March 2020 and 2021.
- The annual interim national evaluation reports will occur in October 2019, 2020 and 2021 and be sent to all evaluation participants with an associated summary.
- The draft final report will be produced in March 2022, and the final report in July 2022.

Along with the above, there will also be summaries from the HSCG and CCG meetings. The above list of reports and their recipients are shown in Table 5.

**Table 5: Evaluation reports to participants and evaluation commissioner**

Year	Participants – Communities and providers in local/regional site studies, national and state/territory participants	Evaluation commissioner – DOH
YEAR 1: 2018–2019 Co-design establishment phase	<ul style="list-style-type: none"> <li>• Tailored evaluation plans</li> <li>• Service provision maps and contextual description</li> </ul>	<ul style="list-style-type: none"> <li>• Progress and site selection report</li> <li>• Summary of co-creation session(s) in which the DOH is a participant</li> </ul>
	Annual interim national evaluation report	
YEAR 2: 2019–2020 Co-creation of knowledge and action	<ul style="list-style-type: none"> <li>• Quantitative data reports</li> <li>• Co-creation and collaborative session summaries</li> </ul>	<ul style="list-style-type: none"> <li>• Progress report</li> <li>• Summary of co-creation session(s) in which the DOH is a participant</li> </ul>
	Annual interim national evaluation report	
YEAR 3: 2020–2021 Co-creation of knowledge and action	<ul style="list-style-type: none"> <li>• Quantitative data reports</li> <li>• Co-creation and collaborative session summaries</li> </ul>	<ul style="list-style-type: none"> <li>• Progress report</li> <li>• Summary of co-creation session(s) in which the DOH is a participant</li> </ul>
	Annual interim national evaluation report	

Year	Participants – Communities and providers in local/regional site studies, national and state/territory participants	Evaluation commissioner – DOH
YEAR 4: 2021–2022 Co-creation of knowledge and action focused on transition and final reporting	<ul style="list-style-type: none"> <li>• Quantitative data reports</li> <li>• Co-creation and collaborative session summaries</li> </ul>	<ul style="list-style-type: none"> <li>• Summary of co-creation session(s) in which the DOH is a participant</li> </ul>
Draft and final national evaluation report		

### 6.3.2. Final report

As described above, a first draft of the final report will be produced in March 2022 and discussed with the DOH, the HSCG and the CCG, and all sites and national and state/territory evaluation participants via the co-creation and collaborative sessions. Once this has occurred the report will be finalised and reviewed for delivery in July 2022.

The draft and final reports will provide timely information for the 2023 revision of the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan*.<sup>80</sup>

### 6.3.3. Dissemination

Section 8 describes the extensive communications and dissemination strategies that will be employed over the four years of the evaluation.

## 7. Implementation

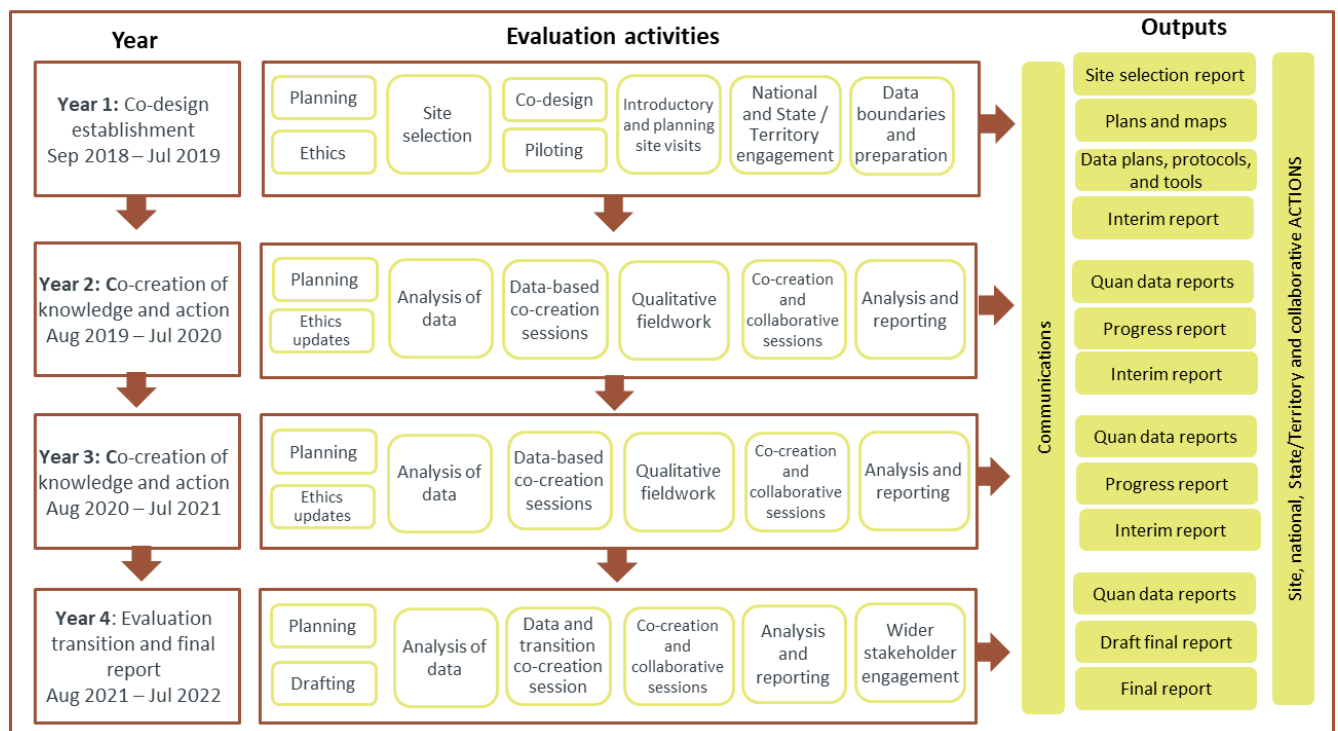
This section outlines the evaluation implementation plan, provides a timeline of the key activities, describes the governance arrangements and lists the primary stakeholders who are likely to be involved in the evaluation. It also discusses the application of the evaluation’s guiding principles and evaluation standards, and the ethics process that will be followed. The section concludes a discussion of the risks.

### 7.1. Implementation of the evaluation over four years

Figure 10 provides a high-level illustration of what will occur each year of the evaluation. This is followed by an overview of the key components, plus a detailed description of what will happen in each of the four years of the evaluation.

The implementation plan is based on a start date of 1 September 2018. Year 1 will conclude on 31 July 2019, so that in Years 2-4, the first round of visits to sites can occur prior to Christmas and before the wet season in northern Australia. If the evaluation starts later than 1 September 2018, the implementation plan will need to be adjusted.

**Figure 10: Four-year evaluation implementation overview**

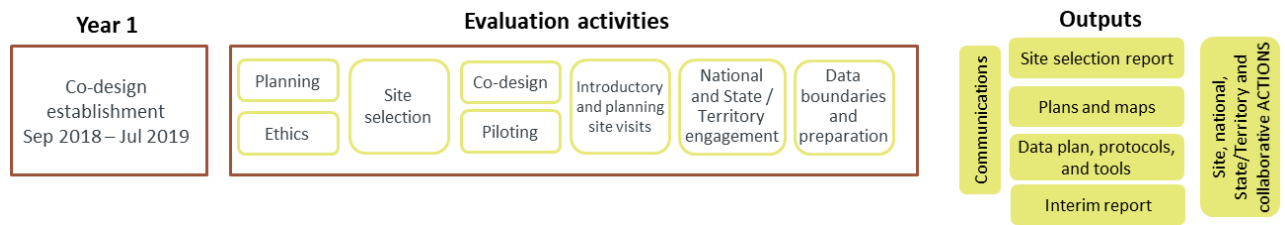


Each year of the evaluation will involve:

- Planning, piloting and an ethics application or amendments as required. The evaluation tools will be piloted each time a new set is created. Planning will occur across the evaluation and in conjunction with each of the sites and state/territory and national engagements on an annual basis.
- Once the sites and data boundaries have been confirmed, there will be an initial production of baseline quantitative data followed by one set of analysed data for each of the sites and the state/territory and national engagements. There will be additional quantitative data analysis as required for the collaboratives in Years 2–4.
- On average, two visits to each of the sites. During Year 1, there may be two or three site visits depending on the introductory and planning processes required by the sites. For Years 2–4, the number of visits may vary between one to three depending on the intensity of involvement desired by the site. A four-month period for site visits has been allowed to enable the full tranche of visits to occur, along with leeway for people’s unavailability due to work-life events, and other events beyond our control (such as weather, accidents, transport malfunctions).
- One or two engagements with national and state/territory stakeholders. The engagements will be a mix of fieldwork and co-creation sessions.
- One or two sessions for each collaborative, up to a maximum of three collaborative sessions per year, for Years 2–4.
- Summary reports for each of the co-creation and collaborative sessions, and the HSCG and CCG meetings (see below).
- A planning and training session for the evaluation team before the site visits to explain and interpret data for each site and to plan the co-creation sessions.
- Two evaluation team reflection and planning sessions towards the end of the site visits. These will focus on analysing and synthesising the information gathered to date in relation to the evaluation questions, process learnings and identifying the focus for the evaluation over the next six months. The evaluation team reflection and planning sessions will feed into sessions held with the DOH, the HSCG and CCG sessions (see below) and the March and October reports to the DOH. Emerging findings will be presented to the sites, and national and state/territory participants as part of the co-creation and collaborative sessions.
- Two meetings of the Health Sector Co-design Group and the national Community Co-design Group – the latter commencing in Year 2. These meetings will focus both on the progress of the evaluation and on the emerging findings.
- A progress report to DOH in March.
- An interim national evaluation report, and accompanying summary report, in October which will be available to all evaluation participants. In Year 4 these will become the draft and final evaluation report.

### 7.1.1. Year 1: Co-design establishment phase

Figure 11: Year 1: Co-design establishment phase



#### Focus

The focus of this year is on establishing the evaluation. This includes:

- detailed evaluation planning, team and tool development, training, seeking ethics approval and piloting
- quantitative data feasibility analysis and plan for answering the evaluation questions
- selecting and negotiating with the evaluation sites
- co-designing the tailored site evaluation plans, mapping the provision of services in each of the sites, and development of in-depth contextual background information
- re-engaging with national and state/territory stakeholders and developing tailored evaluation plans.

#### Outputs

The outputs over the establishment phase will include:

- a site selection report
- site evaluation plans, service provision maps and contextual description, and national and state/territory evaluation plans
- quantitative data feasibility analysis and plan for answering the evaluation questions, data protocols and tools
- ethics application
- interim national evaluation report.

The interim report is the first version of the evaluation report, which will build progressively over the evaluation.



## Site selection

Once the number of sites has been agreed with the DOH, it is likely that we will need to propose a greater number of sites for selection given that some may decline or be unable to engage effectively with the evaluation. Each of the Health Partnership Forums will be approached to assist with the selection of the sites.

The criteria for site selection are that they will cover a range of:

- major city, inner regional, outer regional, remote and very remote locations
- Aboriginal and Torres Strait Islander populations and population densities
- levels of IAHP funding, including a site or sites that do not receive IAHP funding
- programs or services targeting hard-to-reach groups, such as prisoners, that may or may not receive IAHP funding
- models of PHC practice and care
- models of PHC governance and funding
- population groups, including across life stages (babies, childhood, young people, adults, older people) and 'hard-to-reach' groups (e.g. people with disabilities, mental health, LGBTI, prisoners/those in detention, transient people (including parkies/long grassers), young men, young people in home care/wards of state, at boarding school, and/or disengaged)
- those who regularly seek to participate in evaluation activity and those who do less so.

Sites will be distributed across all states and territories, providing opportunities for meaningful engagement for state/territory level organisations as described in the evaluation design. We propose that one site occurs in the Australian Capital Territory and in the Torres Strait Islands, with two plus sites in each of the seven other states and territories – Tasmania, New South Wales, Queensland, Victoria, South Australia, Western Australia and the Northern Territory.

## Site establishment

During the establishment phase, the proposed sites will be visited twice. The first visit will focus on meeting people, providing them with information and inviting their participation in the evaluation through key informant and group discussions. It will also include preliminary co-design discussions about tailoring the evaluation design to fit the site context, identifying the evaluation questions (and potentially others) and evaluative criteria of importance to the site, and sourcing information on the provision of IAHP, PHC and other health services, and relevant contextual factors.

Preliminary discussion will also occur about potential site-based governance mechanisms for the evaluation, site-based resourcing provided by the evaluation, capability development and who will sign a Memorandum of Understanding (MOU) on behalf of the site. The MOU will outline roles, responsibilities and communication processes. The agreed site-based evaluation plan will become an attachment to the MOU.

The second visit will continue negotiations and hopefully confirm the site's participation and signing of the MOU. A third visit will be undertaken to complete the process if required.

During the second, and possibly third visit, the appropriate data boundaries for the site will be identified. Co-designing the tailored site evaluation plan will continue, along with mapping the provision of the IAHP, PHC and other health services, and an in-depth description of the relevant contextual factors (informed by other relevant work such as the PHN needs analyses).

Sites are to be established through engagement with both services and community groups. Potential site participants are listed in Section 7.3, along with potential national and state/territory participants.

### **National and state/territory engagement**

An establishment process, like that described above for the sites, will also occur with national and state/territory stakeholders, many of whom will already be familiar with the evaluation from Phase 1. Meetings will be held to provide an overview of the evaluation design, their specific roles and participation, negotiate the MOUs and develop tailored evaluation plans.

### **Emergence of collaboratives**

Given that the intention of the collaboratives is to respond to cross-cutting themes emerging through the evaluation findings, it is not anticipated that these will occur until Year 2.

### **Data**

Following the confirmation of the site boundaries, the evaluation will proceed to work with the DOH to prepare quantitative data reports for the beginning of Year 2. Prior to the production of the data reports, a trial run of the data will be organised to test the extraction process, clean the datasets and respond to any identified issues. The annual site data reports will include analyses of population and site characteristics data, IAHP data, nationally available clinical data, and possibly administrative, hospitalisation, mortality and morbidity data, and, for the in-depth sites, additional clinical data. Refer Section 5 for a full discussion regarding data.

### **Fieldwork protocols, tools, training and piloting**

In preparation for each of the site visits in Year 1 and over Years 2–4, visit protocols and fieldwork tools will be developed and piloted, along with the training of team members in their use and purpose. We propose selecting and developing a close relationship with a site in NSW to pilot all site protocols, fieldwork tools and processes to enable refinement and adaptation before proceeding on a large scale. Several of the evaluation team members are based in NSW and have strong connections with several Aboriginal and Torres Strait Islander communities and health services.

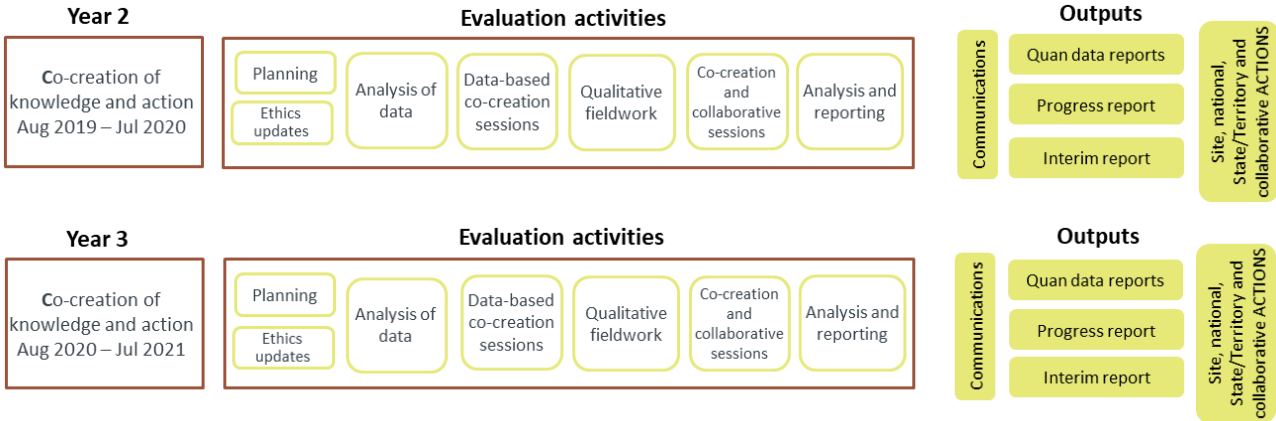
### **Ethics**

Appendix 8 outlines the ethics process to be followed by the evaluation. If the evaluation commences on 1 September 2018, we will apply for ethics approval for the overall approach and use of data in December 2018, supplemented by an amendment in June 2019 once other data

requirements have been established and fieldwork tools developed. There may be subsequent amendments required in later years given the iterative nature of the evaluation.

**7.1.2. Years 2 and 3 – Co-creation of knowledge and action**

**Figure 12: Years 2 (12a) and 3 (12b) – Co-creation of knowledge and action**



**Focus**

The focus of Years 2 and 3 is on the co-creation of knowledge and actions to improve health service design, delivery and outcomes, across the evaluation at site, national and state/territory levels and through the collaboratives.

**Outputs**

The outputs for Years 2 and 3 are:

- quantitative data reports for sites, national and state/territory engagements and collaborative sessions
- a progress report to DOH
- an interim national evaluation report to all participants.

**Cycles**

Years 2 and 3, at each level of the evaluation (sites, national, state/territory), will be guided by a Plan-Do-Study-Act cycle. We anticipate each cycle will take a year, unless some sites want to engage intensively and, for example, complete three cycles over two years.

- The ‘Plan’ component of the cycle involves reflecting on and adapting the overall and tailored evaluation plans, development of tools, training and piloting, and preparation of the quantitative data reports.
- The ‘Do’ component involves co-creation sessions focused on making meaning of data and undertaking qualitative fieldwork.

- The 'Study' component involves reflection, analysis and reporting by the evaluation team, including sessions held with DOH. Importantly it involves co-creation and collaborative sessions, focused on the production of knowledge and identification of recommended actions, to be held with the sites, national and state/territory participants and the collaboratives. Emerging evaluation findings will be presented and analysed as part of these sessions.
- The 'Act' component of the cycle is the site, national, state/territory and collaborative participants implementing the actions identified in the co-creation sessions, with support from the evaluation team as appropriate. The evaluation team will track what occurs with the proposed actions.

### **Site visits**

The number of site visits to occur each year, and visitation processes, will be worked out as part of the co-design with each site. We anticipate that, on average, there will be two visits annually to each of the sites. However, whether one, two or three visits occur will depend on the intensity of involvement desired by the site. The number of visits may also be fluid between years. For example, a site may be more active one year compared to another due to a particular issue or significant event that may impact on people's availability for a site visit.

During the 'Plan' and 'Do' part of the cycle, the visit(s) will include:

- A co-creation session focused on the quantitative data. This will inform the focus of the interviews and community focus groups, along with the identification of any additional local evaluation questions.
- Qualitative fieldwork. This will involve key informant interviews in the general sites. The in-depth sites will also have more intensive key informant interviews, community focus groups, and the collection of additional clinical indicator data if this is to occur.

During the 'Study' part of the cycle, the visit will be focused on co-creation sessions making meaning of the quantitative data and the qualitative information gathered, discussing emerging evaluation issues and findings, and collectively problem solving and identifying solutions and recommended actions.

Each year or cycle, a visit will conclude with a site evaluation reflection process checking on progress against and the relevancy of the site-specific evaluation plans, updating these plans, reflecting on how well the evaluation process is working and what could be improved.

### **National and state/territory engagement**

The national and state/territory engagement will be similar to that described for the sites. We anticipate that, on average, two engagements will occur each year. Along with the evaluation reports, the engagements will be timed to feed into the October policy review and March budget preparation cycles for national stakeholders.

During the ‘Plan’ and ‘Do’ part of the cycle, the engagement will include:

- A co-creation session focused:
  - At the national level, on analysis of all the quantitative site data and the data for the rest of Australia.
  - At the state/territory level, on analysis of quantitative site data for their state/territory, data for all sites for all of Australia, and data for all of Australia.
- Qualitative fieldwork primarily involving key informant interviews.
- During the ‘Study’ part of the cycle, the engagement will be focused on a co-creation session making meaning of the quantitative data and the qualitative information gathered, discussing emerging evaluation issues and findings, and collective problem solving and identifying solutions and actions. National and/or state/territory stakeholders may also be involved in collaborative sessions.

Each year, there will be an evaluation reflection process, checking on relevancy of the evaluation process and what could be improved for the national and state/territory engagements. Twice-yearly, specific reflection and planning sessions will be held with the DOH, the HSCG and the CCG looking at overall progress in addressing the evaluation questions, objectives and aims.

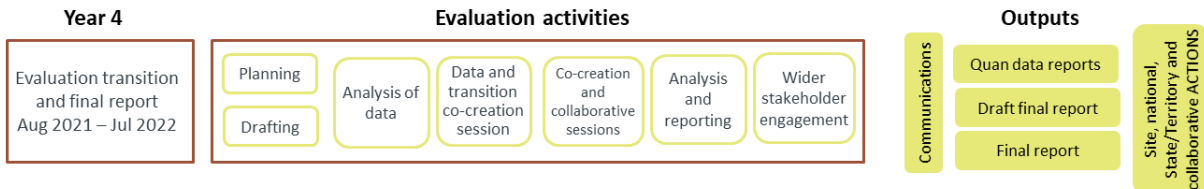
**Collaboratives**

The need for a collaborative will arise through the analysis of quantitative data and qualitative information gathered through the fieldwork across the sites and from the national and state/territory engagement. It may also emerge through stakeholders expressing a strong interest in working on a specific issue that addresses the evaluation aims, objectives and questions.

The evaluation team will provide the relevant data and organise a one to two-day workshop that will focus on analysing and interpreting the data, and collectively problem solving and identifying system solutions and actions. The team will also identify, invite and facilitate the involvement of external experts in the collaborative as appropriate, document the learning and understanding produced through the discussion and the actions to be carried out, and track what occurs with the proposed actions.

**7.1.3. Year 4 – Evaluation transition and final report**

**Figure 13: Year 4 – Evaluation transition and final report**



## Focus

Year 4 has a three-fold focus:

- Addressing the evaluation objective to recommend an approach for monitoring and evaluation over the longer term (5–10+ years), which considers the development of a future accountability framework that measures the public value and health outcomes of the Australian Government’s Aboriginal and Torres Strait Islander-specific PHC investment.
- Identifying the evaluation processes particularly valued by sites and other stakeholders, and how these could be transferred and sustained.
- Drafting and workshopping the final report with all key participants as part of the co-creation and collaborative sessions.

## Outputs

The outputs for Year 4 are:

- quantitative data reports for sites, national and state/territory engagements and collaborative sessions
- a draft final report
- the final report.

## Engagements over the year

The year will start with site visits, national and state/territory engagements, and collaborative sessions as per Years 2 and 3. These will also focus on addressing the above first two foci – some pre-discussion of these will have also occurred at the end of Year 3.

A first high-level draft will be prepared and progressively discussed with the DOH, the HSCG and the CCG in March, and with all sites and national and state/territory evaluation participants via the second and final set of co-creation and collaborative sessions over April and May. The purpose of these sessions will be to share the overall findings, validate and test whether the findings have a fit for the different groups of participants, add interpretation and explanation building around the findings, and discuss the significance of the findings for the IAHP and the PHC system.

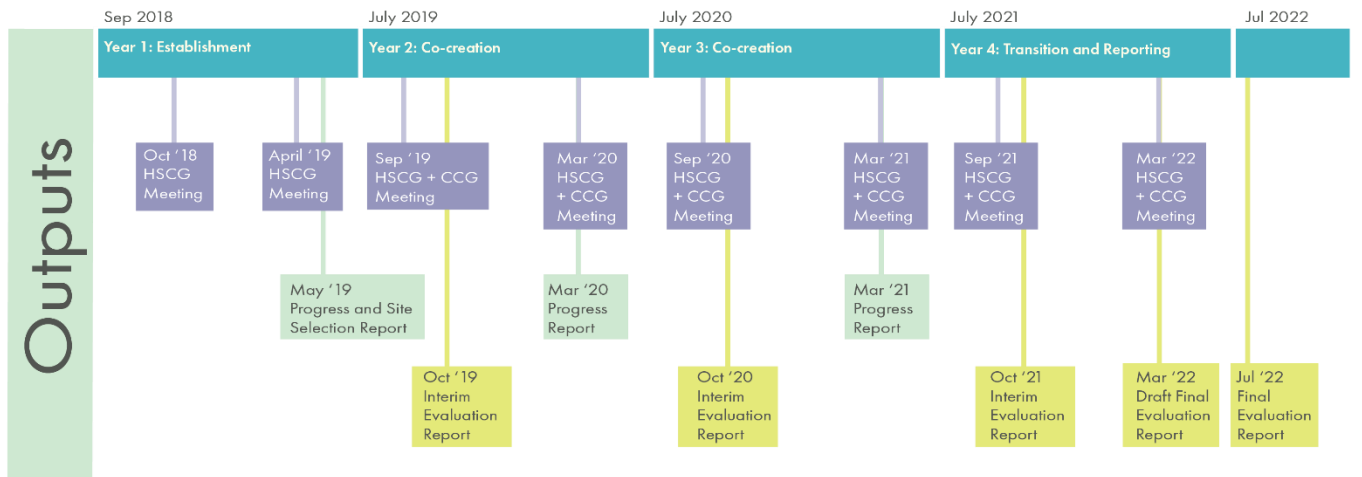
The report will be finalised in July 2022.

*A four-year investment in the evaluation is really positive. There is a need to support local-regional sustainable evaluation activity.*

## 7.2. Timeline

Figure 14 provides a 6-monthly timeline of when the key evaluation activities will occur, across the four years. More detail is provided in Appendix 9.

Figure 14: Timeline of key activities





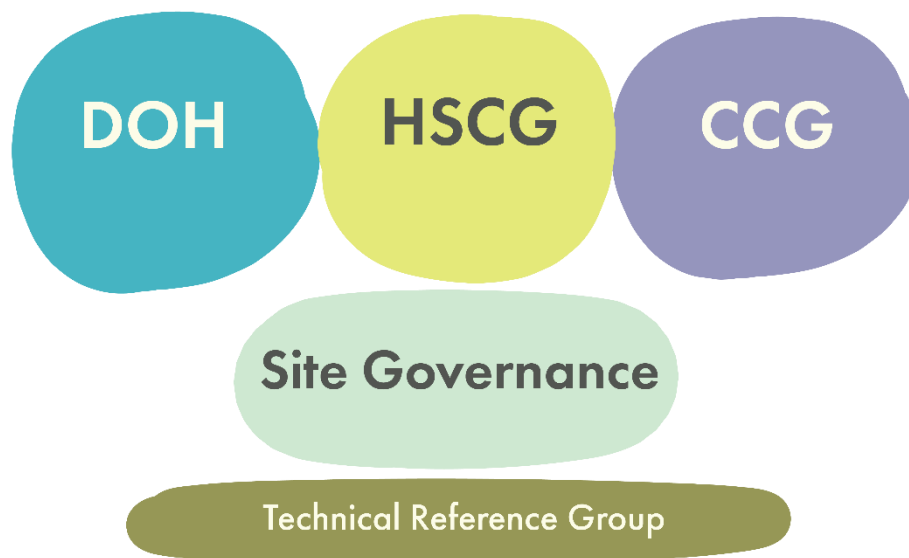
### 7.3. Governance

National governance functions for the evaluation will sit with three groups:

1. Department of Health
2. Health Sector Co-design Group
3. Community Co-design Group.

There will also be site-based governance processes for the evaluation. Each of these governance functions are described in this section, along with the addition of a Technical Reference Group for Phase 2 of the evaluation, and illustrated in Figure 15.

**Figure 15: Governance of the evaluation**



#### 7.3.1. Department of Health

As the commissioner of the evaluation, the DOH will maintain governance oversight and manage the evaluation process. Governance will sit within the Department's Strategic Investment, Data and Evaluation Section, which gives it some separation from the management of the core programs and activities funded under the IAHP. The DOH will, ultimately, approve the evaluation deliverables and manage the contractual relationship with the evaluation team, who will have regular meetings with the DOH to discuss governance and management matters.

#### 7.3.2. Health Sector Co-design Group

The existing HSCG will continue to function through the evaluation implementation period, maintaining its functions of:

- providing advice on the wider co-design and stakeholder engagement process

- being engaged as co-designers in the evaluation design itself
- reviewing and providing feedback on key deliverables
- continuing to provide advice, guidance and leadership in relation to implementation of the evaluation.

The full Terms of Reference for the HSCG are attached as Appendix 2. Importantly, the HSCG includes representatives of the DOH and other organisations where the evaluation will take place, as well as members with evaluation and research expertise from within Aboriginal and Torres Strait Islander communities.

### **7.3.3. Community Co-design Group**

A CCG will be established during the Year 2. It will have a similar function to the HSCG and strengthen governance by adding a community perspective – given the evaluation will also take place within Aboriginal and Torres Strait Islander communities.

In terms of evaluation governance, the HSCG and the CCG will add to the capacity of the DOH to govern the evaluation effectively, and bring greater independence to the governance process. This is important given that the evaluation will include an assessment of the DOH's management and governance of the IAHP.

### **7.3.4. Site governance**

The evaluation team will seek advice from site stakeholders about how governance of the evaluation is best provided at a site level. This may occur via an existing forum or organisation, or a forum specifically established for the evaluation.

Governance at a site level will include negotiating and signing the MOU, agreeing the site evaluation plan, being involved in co-creation sessions and in annual reflections on progress against the site evaluation plan and how well the evaluation processes are working. Site-based governance, along with the evaluation team's guiding principles and standards, will be an important mechanism for ensuring:

- evaluation practice is appropriate for the local culture, practices and circumstances
- guardianship of local knowledge, data and resources and that these are used appropriately
- that the evaluation burden is minimised.

The governance role will not negate the responsibility of the evaluation team for ensuring that the above occurs, nor of working with a range of site stakeholders to co-design the tailored site evaluation plan and in the co-creation sessions. The governance group provides a formal point of contact for the evaluation.

### 7.3.5. Technical Reference Group

The evaluation team will establish its own group of technical experts in primary health care and evaluation, learning and co-design methodologies relevant to the evaluation. This Technical Reference Group (TRG) will provide the evaluation team with independent guidance on the evaluation process as well as quality assurance processes for key deliverables. The evaluation team will liaise directly with members of the TRG, independently of the governance processes described above. The group’s expertise may evolve as the need arises over the course of the implementation phase, but is expected to include skills in:

- health systems
- systems concepts and tools for evaluation
- the evaluation of complex programs
- Indigenous data and knowledge transfer
- co-design and design-led approaches to the design and implementation of strategy, programs, policies and services.

The evaluation team will draw on the expertise of the TRG at key stages, sometimes as a group of experts and sometimes on the expertise of individuals.

### 7.4. Evaluation participants

Table 6 lists the primary stakeholders who are likely to participate at each level of the evaluation.

**Table 6: Primary stakeholders** <sup>(a)</sup>

Site level	State/territory level	National level
Aboriginal and Torres Strait Islander people (both people who use and those who do not use PHC services)	Peak body for ACCHSs	NACCHO
Management and clinical staff in general practices, ACCHSs and other AMSs	State/territory government agencies and public organisations (e.g. departments of health, Aboriginal affairs, housing and justice, mental health commissions)	DOH (especially the Indigenous Health Division)
Board members and consumer representatives of ACCHSs	Australian Government state/territory-based staff (e.g. DOH, PM&C)	PM&C (Health Branch and Indigenous Affairs)
Dental practitioners, pharmacists and other allied health staff working in the wider PHC sector	PHN alliances or state/territory-wide PHNs	Health workforce peak bodies (e.g. National Health Leadership Forum, Royal Australian College of General Practitioners, Australian College of Rural & Remote Medicine)
Other health professionals (e.g. in a locally based hospital, aged care facility, AOD or mental health service, etc.)	Specialist medical/outreach services	Minister for Indigenous Health
	Management and clinical staff at district and base hospitals	Australian Institute of Health and Welfare
		Royal Flying Doctor Service

Site level	State/territory level	National level
Staff from the relevant PHN Visiting medical/outreach staff Local government workers (e.g. with responsibility for water services and housing) Education sector professionals (e.g. local principals or teachers) Justice sector workers Local community organisations (e.g. land councils, youth groups/councils) and community workers (e.g. social workers) Enterprises relevant to specific sites (e.g. shop/supermarket operator in remote communities)	State/territory health workforce bodies State/territory level data custodians (e.g. for hospitalisation datasets)	

(a) Participants in collaboratives may cut across levels

## 7.5. Ethical principles, evaluation standards, cultural respect and ethics approval

The following principles and standards, along with the formal ethics process, will guide the implementation of the evaluation.

### 7.5.1. Ethical principles

The five guiding ethical principles are:

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

These principles were used to guide the evaluation co-design phase (Phase 1). They were identified from a review of principles, ethics and standards specific to working with Aboriginal and Torres Strait Islander people and communities. They were also informed by principles and guidelines for evaluation and co-design. The list of, and rationale for the selection of, these principles and their application in the evaluation is described in Appendix 1.

### 7.5.2. Evaluation standards

The five standards that the evaluation will meet are:

- **Utility** – The utility standards are intended to increase the extent to which stakeholders find evaluation processes and products valuable in meeting their needs.
- **Feasibility** – The feasibility standards are intended to increase evaluation effectiveness and efficiency.
- **Propriety** – The propriety standards support what is proper, fair, legal, right and just, human rights and respect in evaluations.
- **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.
- **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.

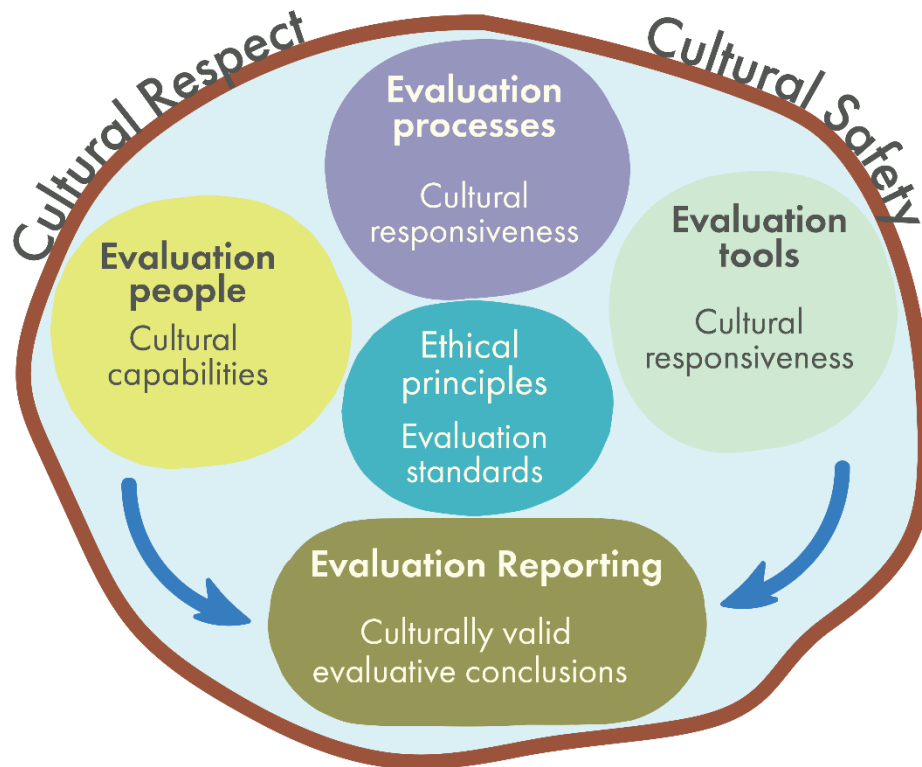
These are the Program Evaluation Standards<sup>81</sup> which are widely recognised by professional evaluation organisations, including the Australasian Evaluation Society, and are intended to increase the quality of evaluation practice. It is understood that evaluation standards for working with Aboriginal and Torres Strait Islander people are being developed by the Lowitja Institute and once published these will also guide the implementation of the evaluation.

Appendix 1 outlines how we will adhere to these standards over the implementation of the evaluation.

### 7.5.3. Cultural respect and safety

Figure 16 illustrates that the evaluation needs to address issues of cultural respect and safety through all aspects of the evaluation – the evaluation team, design, fieldwork, analytical processes, the tools used and the reporting of findings and conclusions. We include a pictorial representation tentatively, knowing that these concepts are contested, their fit with Aboriginal and Torres Strait Islander and other Indigenous peoples' worldviews is challenged, definitions vary and jurisdictions often have their own frameworks.

Figure 16: Addressing cultural respect and safety



#### 7.5.4. Ethics approval

Ethical approval for the evaluation is likely to be obtained through the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) Research Ethics Committee given the recent disestablishment of the DOH Human Research Ethics Committee (HREC). We will also need to discuss with the appropriate jurisdictional level ethics committees whether approval received from a national body will meet their needs or whether we will need to seek separate approval. 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).

Appendix 8 provides a description of the application process, timelines and proposed actions to expediate the process.

#### 7.6. Risks

Key risks identified for the proposed evaluation fall into three categories: financial/resource, implementation, and political. An analysis of the risks and mitigation strategies is included in Appendix 10.

Given the scale of the evaluation, there are potential risks around the budget, availability and resourcing of Aboriginal and Torres Strait Islander and other suitably skilled evaluation team

members, changes to key variables such as cost of travel, number, intensity and distribution of sites, and the expectations/needs of participants to support their participation. These risks will be mitigated through realistic planning and appropriate contingency in the budget.

Implementation risks relate to resources but also include other factors such as:

- the level of interest from potential 'sites', providers and communities
- cross-cultural and local factors that may affect implementation
- existing pressures on providers and burden on stakeholders, providers and communities.

Ongoing engagement, interest and support from the HSCG and the CCG is critical to maintain the integrity of the co-design process, but changes in availability of people, competing demands, and practical issues are expected over a four-year period. There is a risk of the evaluation engaging primarily with higher performing providers and communities with better access to care, with the associated risk of not capturing the issues and perspectives of more marginalised groups within communities. The evaluation is designed with this in mind, so that in-depth or additional work is undertaken to avoid this risk. How it is being addressed will be revisited and reported on as part of regular progress reports.

Unanticipated events, whether physical (e.g. weather events) or social (other important family and community business) may affect participation at every stage. Engagement with providers and communities to hear from them and share their perspectives, may work better in some areas than others. Quantitative data and relevant reporting availability and quality may require more work and time than anticipated. These implementation risks can be managed through careful planning, flexibility within the evaluation processes, and sensitivity to the changing circumstances of regional stakeholders, providers and communities in particular.

Stakeholder expectations will range from the local and informal to the national and formal. The communications around the evaluation have offered opportunity for input but, despite the co-design process, some key Aboriginal and Torres Strait Islander academics, providers or community leaders may express disquiet or have different views about the process or design itself. Providers and communities may have expectations of the evaluation that are unanticipated or beyond the resources available. These issues will need to be heard and negotiated in a respectful and transparent manner. The evaluation is iterative and learning from Aboriginal and Torres Strait Islander people at every level is at the heart of ongoing co-design.

Interest from potential sites or clusters may exceed the evaluation's resources. Differing views of the meaning of data, or the context driving certain outcomes may create tension. The analytical process and reporting will need to include divergent views and multiple perspectives. Major policy shifts, changes to funding quantum or distribution and changing priorities and personnel at national level could affect provider and community engagement in the evaluation or change the way it is viewed. The HSCG and CCG, together with the DOH and the evaluation implementation team, will provide opportunities for robust discussion and support to address issues respectfully and skilfully as the evaluation proceeds. Communications will be important to maintain interest in the positive and important gains possible from the evaluation.

Finally, the evaluation reports will be of wide interest. With the cyclic process and feedback loops, the HSCG and the CCG, and supportive engagement from the DOH and PM&C, there is an



opportunity for transparency and ‘no surprises’. This should ensure that positive developments are celebrated and areas where change is needed can be highlighted openly and with potential solutions in mind. However, sensitivity around areas not working well or resource constraints affecting progress are likely to need careful management, utilising agreed processes.



## 8. Communication strategy

This section assesses the current state of the communication activities that occurred during Phase 1 and outlines the communication strategy for the evaluation.

### 8.1. Statement of purpose

The purpose of this Communications Strategy is to provide a roadmap for communicating the work of the evaluation to key audiences during Phase 2, and for disseminating findings and key messages throughout the evaluation timeframes.

The evaluation will take four years to complete, with work occurring across all states and territories of Australia. Communications activities and requirements will fluctuate over this period. It is important that activities are driven and supported by evaluation partners – the HSCG, the DOH and the evaluation team – given the collaborative, co-design aspects of the evaluation.

Given the above, this Communications Strategy outlines a process that is designed to be **flexible, opportunistic, adaptive** and **partner-driven**.

### 8.2. Current position

During Phase 1 the focus of communications activities was on engaging key groups for consultation, and delivering limited resources for public release mainly via the DOH and evaluation project websites, and the Lowitja Institute eBulletin. The strategy during this phase was deliberately low key to allow space for sensitive discussions and consultations away from the glare of public attention. However, some planks of the communications platform are already in place:

- unique Aboriginal artwork developed by evaluation team member Emma Walke, which is being used to brand the evaluation and communications products, e.g. reports, newsletters, website and communiqués
- a dedicated webpage hosted by Allen + Clarke at [www.IPHCeval.com](http://www.IPHCeval.com) and already populated with key resources
- experienced design and communications specialists appointed
- strong ‘organic’ networks via partner organisations in the Aboriginal and Torres Strait Islander health space that are already being accessed for consultation purposes.

### 8.3. Target audiences

There are five primary audiences for communication activities:

- Aboriginal and Torres Strait Islander health sector
- Aboriginal and Torres Strait Islander communities in all states and territories
- mainstream health sector
- Commonwealth and state policy makers and program managers
- the broader Australian public (particularly towards the end of the evaluation).

### 8.4. Communications objectives

The impact of colonisation has left a legacy of mistrust and suspicion about settler society and governments among many Aboriginal and Torres Strait Islander individuals, communities and organisations. In particular, Aboriginal and Torres Strait Islander perceptions of research has been of something that is 'done' to them by outsiders with little left behind in terms of lasting benefit or positive change. New collaborative approaches to research pioneered over the past 20 years, and the increasing numbers of trained Aboriginal and Torres Strait Islander researchers engaged in community health projects, have gone some way to changing this mindset. However, it is vital that the collaborative ethos of this evaluation is front and centre in all communications activities. With this in mind, this Strategy aims to meet the following objectives:

- Promote positive 'brand' recognition for the evaluation in the Aboriginal and Torres Strait Islander health sector, with an emphasis on the lead role played by Aboriginal and Torres Strait Islander representatives in all decisions and approvals.
- Build and maintain strong relationships with Aboriginal and Torres Strait Islander media networks and key organisations, with Aboriginal and Torres Strait Islander representatives identified for comment as needed.
- Provide clear and concise messaging in all external communication activities.
- Ensure findings and key messages are communicated as widely as possible during the evaluation and especially at the end of the four-year evaluation period.

### 8.5. Key messaging

Messaging around evaluation activities needs to be consistent, clear and focused. The following key messages are at the core of this Strategy:

- While the evaluation is commissioned by the Government, it is being carried out by an independent evaluation team.
- The evaluation team has strong Aboriginal and Torres Strait Islander leadership.
- The evaluation uses best practice methodologies, and outcomes will be evidence-based.

- Outcomes will add value to the PHC system and help meet COAG’s Closing the Gap health targets and 2023 review of the Implementation Plan.
- The evaluation will not be a burden to the Aboriginal and Torres Strait Islander health sector or communities.
- The evaluation will contribute capacity to the Aboriginal and Torres Strait Islander health sector and communities.

## 8.6. Implementation

The nature of the evaluation means that communications activities are likely to be ‘lumpy’, with a strong emphasis on leveraging media opportunities at the start and finish of the evaluation process. However, there will be cyclical opportunities to build positive messaging around the evaluation as it unfolds, with the release of six-monthly HSCG communiqués and newsletters providing opportunities to engage media interest. See Appendix 11 for a schedule of how this Communication Strategy could be rolled out, and the table of potential communications risks and mitigation strategies.

Although most of the activities will be focused on building the evaluation brand in the Aboriginal and Torres Strait Islander health and community space, there will be *ad hoc* opportunities to engage with a broader health and mainstream media audience. In this regard it will be vital to identify spokespeople in advance within the evaluation partnership who can take up these opportunities as they arise.

Communications activities will be decided and driven by evaluation partners with the evaluation team facilitating and coordinating these activities in the background. Existing resources (website, newsletters, communiqués and fact sheets) will continue to be provided and updated as the evaluation rolls out. The website will move to a stand-alone URL address at the start of Phase 2 and will be the hub for all communications, including new activities and opportunities as set out below.

### Aboriginal and Torres Strait Islander media:

There are long-established and well-regarded Aboriginal and Torres Strait Islander-controlled media providers across Australia that are a natural target of communications activities. These include the *Koori Mail*, the *National Indigenous Times*, *Torres News*, NITV, Central Australian Aboriginal Media Association, Radio National’s *Away!* program, the National Indigenous Radio Service and a range of interconnected state and territory-based Aboriginal and Torres Strait Islander radio stations.

### Stakeholder newsletters and journals:

A key way of promoting the evaluation’s rollout is to take advantage of stakeholder publications. Aboriginal and Torres Strait Islander community newsletters; NACCHO health alerts; journals published by professional bodies such as the Australian Indigenous Doctors’ Association, the Australian Medical Association, the Public Health Association of Australia and the Rural Health

Alliance; the Lowitja Institute eBulletin; and Australian Public Service News all present communications opportunities.

### **Social media**

It will be useful for the evaluation to embrace social media, as research tells us that Aboriginal and Torres Strait Islander people engage with it at higher rates than other Australians. It is envisaged the evaluation would initially have its own Twitter account using the evaluation branding, owned by the lead evaluation organisation and administered (including moderation) by the evaluation team and potentially the co-design groups. Using Twitter could help facilitate higher engagement with the evaluation through sharing content and photos during consultations, meetings with officials and conferences, and linking people involved in the evaluation with key communications releases on the website. The handle for the Twitter account would mirror the URL for the website, for example, @IPHCEval or @IPHCEvaluation. Consideration should also be given to using Facebook, should there be a demand for it from key audiences.

### **Networking through workshops and conferences**

This is an often-overlooked avenue for maintaining a health sector profile. Consideration should be given to targeting appropriate health sector and evaluation events to provide updates/presentations on the evaluation and provide commentary via participation in discussion panels. It will be important to identify spokespeople within the evaluation partnership who would be willing to participate in such events and be available for media interviews.

### **Video production**

The production of short videos for use as content on the website, social media platforms, digital display boards and at conference presentations should also be considered. Consultation activities and spokesperson messages would be the focus of these productions.

### **Traditional mainstream media**

A well-placed story in national and local media (print and electronic) can be beneficial in building and maintaining a public profile and costs very little to generate. This can be by way of drafting and distributing media releases; contributing articles and opinion pieces to appropriate media outlets; organising spokespeople to be available at key events such as conferences; and pitching 'exclusive' stories to individual journalists and presenters. Engagement with mainstream media would be largely opportunistic during most of Phase 2 and provide the means to build relationships with individual journalists. This will help with achieving maximum publicity for the evaluation findings and key messages when final findings are released at the end of Phase 2.

## Endnotes

- <sup>1</sup> National Aboriginal Community Controlled Health Organisation. Aboriginal health. Available at: <http://www.naccho.org.au/about/aboriginal-health/definitions/>.
- <sup>2</sup> Mathison, S (ed.). *Encyclopedia of evaluation*. California: Sage Publications, 2005.
- <sup>3</sup> Commonwealth of Australia. *Indigenous Advancement Strategy evaluation*. Canberra: PM&C, Australian Government, 2018.
- <sup>4</sup> Commonwealth of Australia. *Implementation plan for the National Aboriginal and Torres Strait Islander health plan 2013–23*. Canberra: Australian Government, 2013.
- <sup>5</sup> Sentinel Sites Evaluation Award Nomination for Australasian Evaluation Society Award, 2016. Accessed 10 January 2018 at: [https://www.menzies.edu.au/icms\\_docs/SSE\\_award\\_nomination\\_2015.pdf](https://www.menzies.edu.au/icms_docs/SSE_award_nomination_2015.pdf).
- <sup>6</sup> Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS). *Guidelines for ethical research in Australian Indigenous studies*. Canberra: AIATSIS, 2012.
- <sup>7</sup> Australian Health Ministers' Advisory Council (AHMAC), Standing Committee on Aboriginal and Torres Strait Islander Health Working Party. *Cultural respect framework for Aboriginal and Torres Strait Islander health 2004–2009*. Canberra: AHMAC, 2004.
- <sup>8</sup> Australian Health Ministers' Advisory Council's National Aboriginal and Torres Strait Islander Health Standing Committee. *Cultural respect framework for Aboriginal and Torres Strait Islander health 2016–2026*. Canberra: AHMAC, 2016.
- <sup>9</sup> Hunt J. *Engaging with Indigenous Australia – exploring the conditions for effective relationships with Aboriginal and Torres Strait Islander communities*. Issues paper no. 5 produced for Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies, 2013.
- <sup>10</sup> Commonwealth of Australia. *Indigenous Advancement Strategy evaluation framework*. Canberra: PM&C, Australian Government, 2018.
- <sup>11</sup> Commonwealth of Australia 2018. *Indigenous Advancement Strategy evaluation framework: exposure draft*. Canberra: PM&C, Australian Government, October 2017.
- <sup>12</sup> Hunt J. *Engaging with Indigenous Australia – exploring the conditions for effective relationships with Aboriginal and Torres Strait Islander communities*. Issues paper no. 5 produced for Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies, 2013.
- <sup>13</sup> Australian Health Ministers' Advisory Council's National Aboriginal and Torres Strait Islander Health Standing Committee. *Cultural respect framework for Aboriginal and Torres Strait Islander health. 2016–2026*. Canberra: AHMAC, [2016].
- <sup>14</sup> Katz I, Newton BJ, Shona B, Raven M. *Evaluation theories and approaches: relevance for Aboriginal contexts*. Sydney: Social Policy Research Centre, 2016.
- <sup>15</sup> Markiewicz A. Closing the gap through respect, relevance, reciprocity and responsibility: issues in the evaluation of programs for Indigenous communities in Australia. *Evaluation Journal of Australasia* 2012;12(1):19–26.
- <sup>16</sup> Hunt J. *Engaging with Indigenous Australia – exploring the conditions for effective relationships with Aboriginal and Torres Strait Islander communities*. Issues paper no. 5 produced for Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies, 2013.
- <sup>17</sup> Laycock A, Bailie J, Matthews V, Bailie R. Interactive dissemination: engaging stakeholders in the use of aggregated quality improvement data for system-wide change in Australian Indigenous primary health care. *Frontiers in Public Health* 2016 May 3.
- <sup>18</sup> Mila-Schaaf K, Hudson M. The interface between cultural understandings: negotiating new spaces for Pacific mental health. *Pacific Health Dialogue* 2009;15(1).
- <sup>19</sup> Anderson I. 2017 Menzies Oration: Democratising Indigenous data – 21 November 2017. Accessed on 12 January 2018 at: <https://www.pmc.gov.au/news-centre/indigenous-affairs/2017-menzies-oration-democratising-indigenous-data>.

- <sup>20</sup>Bailie R, Griffin J, Schierhout G. Considerations for the applicability and adaptability of a sentinel sites type approach to future evaluations of Indigenous-specific primary health care funding. Brisbane: Centre for Primary Health Care Systems at the Menzies School of Health Research for Australian Government Department of Health and Ageing, 2014.
- <sup>21</sup>Walter M. Data politics and Indigenous representation in Australian statistics. In: Kukutai T, Taylor J, eds. Indigenous data sovereignty. Canberra: ANU Press, 2016.
- <sup>22</sup>Anderson I. 2017 Menzies Oration: Democratising Indigenous data. 21 November 2017. Accessed on 12 January 2018 at: <https://www.pmc.gov.au/news-centre/indigenous-affairs/2017-menzies-oration-democratising-indigenous-data>.
- <sup>23</sup>Ellis B. An overview of complexity theory: understanding primary care as a complex adaptive system. In: Sturmberg J, Martin C, eds, Handbook of systems and complexity in health. New York, NY: Springer, 2012.
- <sup>24</sup>Van Olmen J, Criel B, Van Damme W, Marchal B, Van Belle S, Van Dormael M, et al. Analysing health system dynamics: a framework. Antwerp: ITG Press, 2012.
- <sup>25</sup>Matheson A, Ellison-Loschmann L. Addressing the complex challenge of unmet need: a moral and equity imperative. The New Zealand Medical Journal 2017;130(1452):6–8.
- <sup>26</sup>Pourbohloul B, Kieny M. Complex systems analysis: towards holistic approaches to health systems planning and policy. Bulletin of the World Health Organization 2011;89:242.
- <sup>27</sup>Eppel E, Matheson A, Walton M. Applying complexity theory to New Zealand public policy: principles for practice. Policy Quarterly 2011;7(1):48–55.
- <sup>28</sup>Matheson A, Walton M, Gray R, Lindberg, K, Shanthakumar, M, Fyfe, C, et al. Short report evaluating a community-based public health intervention using a complex systems approach. J Public Health 2017;1–8. Available at: <https://doi.org/10.1093/pubmed/fox117>.
- <sup>29</sup>Matheson A, Walton M, Gray R, Lindberg, K, Shanthakumar, M, Fyfe, C, et al. Short report evaluating a community-based public health intervention using a complex systems approach. J Public Health 2017;1–8. Available at: <https://doi.org/10.1093/pubmed/fox117>.
- <sup>30</sup>Matheson A, Walton M, Gray R, Lindberg, K, Shanthakumar, M, Fyfe, C, et al. Short report evaluating a community-based public health intervention using a complex systems approach. J Public Health 2017;1–8. Available at: <https://doi.org/10.1093/pubmed/fox117>.
- <sup>31</sup>Bailie R, Griffin J, Schierhout G. Considerations for the applicability and adaptability of a sentinel sites type approach to future evaluations of Indigenous-specific primary health care funding. Brisbane: Centre for Primary Health Care Systems at the Menzies School of Health Research for Australian Government Department of Health and Ageing, 2014.
- <sup>32</sup>Sentinel Sites Evaluation Award Nomination for Australasian Evaluation Society Award, 2016. Accessed 10 January 2018 at: [https://www.menzies.edu.au/icms\\_docs/SSE\\_award\\_nomination\\_2015.pdf](https://www.menzies.edu.au/icms_docs/SSE_award_nomination_2015.pdf).
- <sup>33</sup>Council of Australian Governments (COAG). Communiqué. Melbourne: COAG, 20 December 2007 [30 June 2010]. Available at: [http://www.coag.gov.au/coag\\_meeting\\_outcomes/2007-12-20/index.cfm](http://www.coag.gov.au/coag_meeting_outcomes/2007-12-20/index.cfm).
- <sup>34</sup>Close the Gap Campaign Steering Committee. A ten-year review: Closing the Gap strategy and recommendations for reset. Sydney: Close the Gap Campaign Steering Committee, 2018:3.
- <sup>35</sup>Council of Australian Governments (COAG). National Indigenous reform agreement (Closing the Gap), Melbourne: COAG, 2008 [30 June 2010]. Available at: [http://www.coag.gov.au/coag\\_meeting\\_outcomes/2009-07-02/docs/NIRA\\_closing\\_the\\_gap.pdf](http://www.coag.gov.au/coag_meeting_outcomes/2009-07-02/docs/NIRA_closing_the_gap.pdf).
- <sup>36</sup>Commonwealth of Australia. Closing the Gap: Prime Minister's 2018 report. Canberra: PM&C, Australian Government, 2018.
- <sup>37</sup>Commonwealth of Australia. Closing the Gap: Prime Minister's 2018 report. Canberra: PM&C, Australian Government, 2018:38.
- <sup>38</sup>Commonwealth of Australia. Closing the Gap: Prime Minister's 2018 report. Canberra: PM&C, Australian Government, 2018:104.
- <sup>39</sup>National Aboriginal Community Controlled Health Organisation Website: [www.naccho.org.au](http://www.naccho.org.au)
- <sup>40</sup>Section 2.2 sourced from the Department of Health. Request for tender for the provision of services to evaluate the effectiveness of primary health care for Aboriginal and Torres Strait Islander people. Canberra: Australian Government, 2017.
- <sup>41</sup>Commonwealth of Australia. National Aboriginal and Torres Strait Islander health plan 2013–23. Canberra: Australian Government, 2013.



- <sup>42</sup>Commonwealth of Australia. Implementation plan for the National Aboriginal and Torres Strait Islander health plan 2013–23. Canberra: Australian Government, 2015.
- <sup>43</sup>Commonwealth of Australia. National Aboriginal and Torres Strait Islander health plan 2013–23, Canberra: Australian Government. 2013:1.
- <sup>44</sup>Australian Health Ministers' Advisory Council, Standing Committee on Aboriginal and Torres Strait Islander Health, Cultural respect framework 2016–2026 for Aboriginal and Torres Strait Islander health: A national approach to building a culturally respectful health system. Canberra: AHMAC, 2016.
- <sup>45</sup>Starfield B, Shi L. Policy relevant determinants of health: an international perspective. *Health Policy*. 2002 Jun;60(3):201-18.
- <sup>46</sup>Griew R, Tilton E, Cox N, Thomas D. The link between primary health care and health outcomes for Aboriginal and Torres Strait Islander Australians, 2008. A Report for the Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing.
- <sup>47</sup>NACCHO. Aboriginal Health. Definitions. <http://www.naccho.org.au/about/aboriginal-health/definitions/>.
- <sup>48</sup>Gibson O, Lisy K, Davy C, Aromataris E, Kite E, Lockwood C, et al. Enablers and barriers to the implementation of primary health care interventions for Indigenous people with chronic diseases: a systematic review. *Implementation Science*. 2015;10(1):71.
- <sup>49</sup>Gomersall JS, Gibson O, Dwyer J, O'Donnell K, Stephenson M, Carter D, et al. What Indigenous Australian clients value about primary health care: a systematic review of qualitative evidence. *Australian and New Zealand Journal of Public Health*. 2017;41(4):417–23.
- <sup>50</sup>McCalman J, Bainbridge R, Percival N, Tsey K. The effectiveness of implementation in Indigenous Australian healthcare: an overview of literature reviews. *International Journal for Equity in Health*. 2016;15:47.
- <sup>51</sup>Department of Health. My life my lead – opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health: report on the national consultations. Canberra: Australian Government, 2017.
- <sup>52</sup>Baum F, Legge D, Freeman T, Lawless A, Labonte R, Jolley G. The potential for multi-disciplinary primary health care services to take action on the social determinants of health: actions and constraints. *BMC Public Health* 2013;13:460. Available at: <https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-460>.
- <sup>53</sup>Carey TA, Wakerman J, Humphreys JS, Buykx P, Lindeman M. What primary health care services should residents of rural and remote Australia be able to access? A systematic review of 'core' primary health care services. *BMC Health Services Research*. 2013;13(1):178.
- <sup>54</sup>Wakerman J, Shannon C. Editorial: Strengthening primary health care to improve Indigenous health outcomes. *Med J Aust* 2014;204(10):363–4.
- <sup>55</sup>Panaretto K, Wenitong M, Button S, Ring I. Aboriginal community controlled health services: leading the way in primary care. *Med J Aust* 2014;200(11):649–52. <https://www.mja.com.au/journal/2014/200/11/aboriginal-community-controlled-health-services-leading-way-primary-care>
- <sup>56</sup>Tilton E, Thomas D. Core functions of primary health care: a framework for the Northern Territory. Melbourne: The Lowitja Institute, 2011.
- <sup>57</sup>Thomas SL, Wakerman J, Humphreys JS. Ensuring equity of access to primary health care in rural and remote Australia – what core services should be locally available?. *International Journal for Equity in Health* 2015;14:111.
- <sup>58</sup>Bailie J, Schierhout G, Laycock A, et al. Determinants of access to chronic illness care: a mixed-methods evaluation of a national multifaceted chronic disease package for Indigenous Australians. *BMJ Open* 2015;5:e008103. doi: 10.1136/bmjopen-2015-008103.
- <sup>59</sup>Close the Gap (CtG) Steering Committee, Submission to the Australian Government for the development of a National Aboriginal and Torres Strait Islander health plan. Sydney: CtG, 2012.
- <sup>60</sup>Commonwealth of Australia. Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families. Canberra: Commonwealth of Australia, 1997.
- <sup>61</sup>Department of Health, Indigenous Australians' Health Programme: programme guidelines. Canberra: DOH, Australian Government, 2018.
- <sup>62</sup>Commonwealth of Australia. National Aboriginal and Torres Strait Islander health plan 2013–23. Canberra: Australian Government, 2013.

- <sup>63</sup>Department of Health. Indigenous Australians' Health Programme: Budget overview. Canberra: Australian Government, 2017.
- <sup>64</sup>Australian Institute of Health and Welfare. Health expenditure Australia 2015–2016. Health and Welfare Expenditure Series, Number 58. Canberra: AIHW, 2017.
- <sup>65</sup>Department of Health. Indigenous health: Key statistics fact sheet. Canberra: Australian Government, 2017.
- <sup>66</sup>Department of Health. Request for tender for the provision of services to evaluate the effectiveness of primary health care for Aboriginal and Torres Strait Islander people: Attachment D – Rationale for the evaluation and Attachment E – Towards achieving the vision. Canberra: Australian Government, 2017.
- <sup>67</sup>Van Olmen J, Criel B, Van Damme W, Marchal B, Van Belle S, Van Dormael M, et al. Analysing health system dynamics; a framework. ITG Press; 2012.
- <sup>68</sup>Commonwealth of Australia. Implementation plan for the National Aboriginal and Torres Strait Islander health plan 2013–23, Canberra: Australian Government, 2013.
- <sup>69</sup>NSW Health. A program and services evaluation framework for Aboriginal and Torres Strait Islander community health. Sydney Health Group 2017.
- <sup>70</sup>Adapted from Greenhalgh T, Jackson C, Shaw S, Janamian T. Achieving research impact through co-creation in community-based health services: literature review and case study. *The Milbank Quarterly* 2016;94(2):392–429.
- <sup>71</sup>Kendall E, Sunderland N, Barnett L, Nalder G, Matthews C. Beyond the rhetoric of participatory research in Indigenous communities advances in Australia over the last decade. *Qualitative Health Research* 2011 Dec;21(12):1719–28. Available at: <http://hdl.handle.net/10072/41665>.
- <sup>72</sup>Sheehan NW. Indigenous knowledge and respectful design: an evidence-based approach. *Design Issues* 2011 Autumn;27(4).
- <sup>73</sup>Department of the Prime Minister and Cabinet, New Zealand Government. The Policy Project: Policy methods toolbox – design thinking. Wellington: New Zealand Government, 2017. Accessed 5 September 2017 at: <https://dpmc.govt.nz/our-programmes/policy-project/policy-methods-toolbox/design-thinking#design>.
- <sup>74</sup>The Free Dictionary. Design thinking. Encyclopaedia article, [n.d.]. Accessed 5 September 2017 at: <https://encyclopedia.thefreedictionary.com/design+thinking>.
- <sup>75</sup>IDEO. The field guide to human-centered design. San Francisco CA: Design Kit, 2015. Available at: <http://www.designkit.org/resources>.
- <sup>76</sup>Williams B. Using systems concepts in evaluation design: A workbook. Wellington: Bob Williams, 2016:4.
- <sup>77</sup>Patton M Q. Developmental evaluation – applying complexity concepts to enhance innovation and use. New York: The Guilford Press, 2011:1–2.
- <sup>78</sup>Manzano, A. The craft of interviewing in realist evaluation. *Evaluation* 2016;22:342–60. Accessed 11 June 2018 at: <https://www.researchgate.net/publication/300065986>.
- <sup>79</sup>Davidson, J. Evaluation methodology basics: The nuts and bolts of sound evaluation. California: Sage Publications, 2005.
- <sup>80</sup>Commonwealth of Australia. National Aboriginal and Torres Strait Islander health plan 2013–23. Canberra: Australian Government, 2013.
- <sup>81</sup>Yarborough, D. B., Shulha, L. M., Hopson, R. K., & Caruthers, F. A. *The program evaluation standards: A guide for evaluators and evaluation users* (3rd ed.). California: Sage Publications 2011.