“Bandaid for a bullet wound”: the inconsistent recognition of Indigenous rights and social determinants of Indigenous health in ‘Closing the Gap’ policy implementation in early childhood

By

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Thesis
Submitted to Flinders University
for the degree of

Doctor of Philosophy

College of Medicine and Public Health
4th December 2020

CONTENTS

SUMMARY

In this thesis I examine the Australian government's 'Closing the Gap' (CTG) strategy in early childhood and how it has been implemented to answer the following questions:

1. To what extent are Indigenous rights prioritised and acted on within the 'Closing the Gap' strategy in early childhood?
2. To what extent are social determinants of Indigenous health recognised and acted on within the implementation of the 'Closing the Gap' strategy in early childhood?
3. How does the experience of the 'Closing the Gap' strategy in early childhood compare in Shepparton (Victoria) and Southern Adelaide (South Australia)?
4. To what extent has a decolonising approach to health equity been implemented through the 'Closing the Gap' strategy in early childhood?

There is evidence that even when Indigenous rights, including self-determination, and social determinants of Indigenous health are mentioned in policy documents, they are not consistently enacted during implementation. Criticism of the CTG strategy is that, like past policies, it is deficit based and problematises Aboriginal and Torres Strait Islander people. My review of the literature identified that understanding policy implementation and the recognition and action on Indigenous rights and social determinants of Indigenous health in early childhood was a gap in knowledge.

Drawing on a decolonising approach to research at the interface of knowledge, critical social constructivism, and an institutionalist framework, I analysed 12 CTG policy documents relevant to early childhood. Then I conducted semi-structured in-depth interviews in Shepparton and Southern Adelaide with 16 participants in each case study to explore the way that policy had been implemented. In Shepparton, the presence of a large Aboriginal community-controlled health organisation influenced policy implementation. In Southern Adelaide, policy was implemented through mainstream services with targeted programs for Aboriginal children and families.

My finding suggest that Indigenous rights can be named and recognised, implied, or undermined and ignored in policy. Implementation of early childhood services occurs through those offered by Aboriginal people for Aboriginal people, by other services with targeted programs, and in mainstream services that are universally accessible. Policy actors reported some influence over how policy is implemented by prioritising culture, identity and belonging, even though these social determinants of Indigenous health were not always recognised in policy. Despite local influence on policy implementation, these actions did not change the deficit discourse, colonial power relations, or the representation of Aboriginal people as a problem in policy documents. Therefore, the CTG strategy was compared to a “Bandaid for a bullet wound” in the way that policy actions could not heal wounds caused by ongoing colonisation and exertion of power over Aboriginal people. Despite the limitations of the CTG strategy, Indigenous sovereignty, hope, and advocacy for the right to an Aboriginal childhood remain. In discussing implications of the research, I advocate for moving beyond the rhetoric of “working with” Aboriginal people towards self-determination, and I highlight the importance of Aboriginal community-controlled organisations in early childhood.

As a non-Indigenous researcher, this research required transformational unlearning to unravel my thinking so that I could weave in new knowledge. I finish this thesis with my reflection on conducting research at the interface of knowledge.

DECLARATION

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

I confirm that I am a recipient of RTP support through the Australian Government Research Training Program Scholarship.

This work was supported by the NHMRC Centre of Research Excellence in the Social Determinants of Health Equity: policy research on the social determinants of health equity (APP1078046). I received a PhD scholarship funded by the NHMRC which was topped up by Flinders University.

Signed Emma George

Date 23rd September 2020

ACKNOWLEDGEMENTS

I live, work, play and learn on the land of the Kaurna people of the Adelaide plains. I pay my respect to the Elders past and present, and I acknowledge the deep feelings of attachment and relationship of the Kaurna people to country. It has been a privilege to conduct research in Southern Adelaide and I offer an acknowledgement in Kaurna language:

Kaurna miyurna, Karuna yarta, ngadlu tampinthi.

I also pay respect to the Yorta Yorta and Bangerang people of the Greater Shepparton Region. I was warmly welcomed onto country and am very grateful for the knowledge so generously shared with me. To all the people who participated in this research, the research partner in Shepparton, Rumbalara Aboriginal Cooperative, and the Joining Hands and Minds Network in Southern Adelaide, thank you for your insight, wisdom and knowledge on policy implementation.

There are many people, colleagues, friends and family who have supported me to complete this thesis and enriched my learning. I am truly thankful of their time, encouragement, patience and advice. I acknowledge and thank my supervisors: Professor Fran Baum, Associate Professor Tamara Mackean and Dr Matt Fisher who have guided me along the way. Fran's vision for this research and leadership in public health is inspirational. She challenged me and encouraged me, and after every supervision meeting I walked away feeling affirmed and ready for whatever was to come next. Tamara's holistic approach to supervision strengthened me, and her sharing of Indigenous knowledge has sharpened my mind and softened my heart. Matt's availability to answer all my questions and keep me focused in practical and philosophical ways still amazes me. All three of my supervisors treated me as a valued member of the research team, and this is something I will always cherish.

Thank you to Professor Sharon Friel and all the members of the NHMRC Centre for Research Excellence in the Social Determinants of Health Equity. Our research retreats showed me the importance of public health policy research. I received a full time PhD Scholarship for the first 2 years of my PhD through the CRE-HE which allowed me to be fully immersed in the literature and data which proved invaluable.

The Southgate Institute for Health, Society and Equity was an incredible environment to learn and grow as a researcher. There was stimulating conversation at morning tea, and a visiting Koala in the tree outside my window. But it was the people who have made a lasting impression on me. The late Dr Kathryn Browne-Yung was the PhD Coordinator in Southgate and a member of the CRE-HE. She was always available to chat, debrief, and talk about the footy. I appreciated every kind and encouraging word and I miss her. In addition, I acknowledge the friendship and support I received from others working and studying with me at Flinders University: Paula Lynch, Helen Hazelwood, Cat Moller, Annabelle Wilson, Toby Freeman, Kingsley Whittenbury, Jane Fitzgerald, Eunice Okyere, Hailay Gesesew, Kristen Foley, Miriam Vandenburg and Alice Windle.

During my PhD, I was challenged by an occupational therapy professor not to lose the occupation from my research in public health. This helped me to see the occupational perspective I brought to community engagement. I acknowledge the support I received from my occupational therapy colleagues and friends who showed interested in my work, attended conference presentations, and encouraged me to continue on my journey in public health. Special thanks to Sandra Mortimer, Ellice Willcourt, Ali Dymmott and Kylie Vogt for supporting me to reach my goals while balancing teaching in allied health. In addition, I acknowledge the encouragement and support I received from Professor Rachel Gibson to complete this thesis while working at the University of Adelaide.

This research would not have been possible without peer mentoring from Aboriginal friends and colleagues. To my dear friends Tirritpa Ritchie and Tina Brodie, your generosity and kindness towards me every time we catch up means the world to me. Thank you for helping me reflect on my own learning and unlearning. To Courtney Ryder and Rolland Wilson, thank you for the coffee catch ups. Your advice has challenged my thinking and enriched my work.

Finally, to my husband Simon, our children Lachie, Tommy, and Charlotte, and my parents Joe and Joy, thank you for your unwavering love and understanding as I devoted so much of myself to this research.

No professional editing service has been utilised in the development of this thesis.

PUBLICATIONS FROM THE RESEARCH

Journal Articles

George, E., Mackean, T., Baum, F., & Fisher, M. (2019) 'Social Determinants of Indigenous Health and Indigenous Rights in Policy: A scoping review and analysis of problem representation' *International Indigenous Policy Journal,* 10(2) https://doi.org/10.18584/iipj.2019.10.2.4 . 4 citations: Google Scholar

Conference Presentations

George, E., & Mackean, T. (2019). 'The power of occupation as a method for community engagement in decolonising research: a comparative case study on implementation of the 'Closing the Gap' strategy'. Paper presented at the *Occupational Therapy Australia 28th National Conference and Exhibition*, Sydney Australia, 10-12 July

Mackean, T., Fisher, M., **George, E.,** Friel, S., & Baum, F. (2019). 'Improving 'Closing the Gap' policy to support Aboriginal and Torres Strait Islander sovereignty and wellbeing'. Paper presented at the *Lowitja Institute International Indigenous Health and Wellbeing Conference,* Darwin Australia, 18-21 June.

George, E., & Mackean, T. (2018). 'To what extent are Indigenous Rights recognised within the Australian government's 'Closing the Gap' strategy in early childhood: an analysis of national policy documents 2009-2016'. Paper presented at the *International Political Science Association 25th World Congress of Political Science,* Brisbane, Australia, 21-25 July.

George, E., & Mackean, T. (2017). 'Reflections on a decolonising approach in research at the interface of knowledge'. Paper presented at the *Occupational Therapy Australia 27th National Conference and Exhibition*, Perth, Australia, 18-21 July

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CHAPTER 1: INTRODUCTION

In this Chapter I introduce the context of my research and highlight the importance of early childhood. I give a detailed description of the Australian government's Closing the Gap strategy and discuss the mixed progress in addressing the gaps in health outcomes between Aboriginal and Torres Strait Islander people and non-Indigenous Australians. Finally, I summarise the structure of the thesis with a brief outline of each Chapter.

1.1 Research context

Aboriginal and Torres Strait Islander people in Australia have poorer health status than other Australians (Australian Institute of Health and Welfare, 2018). This is a health inequity that is unfair and avoidable (Australian Human Rights Commission, 2020). The Australian government developed the 'Closing the Gap' (CTG) strategy in 2007 to address gaps in health, education and employment outcomes. For over a decade, many policies have been implemented directly under the banner of CTG, and other broader policies have included objectives and actions linked to meeting CTG targets. Despite Australian government bipartisan support, progress towards closing the gap in health inequity has been mixed at best, or not on track to meet the proposed targets (Close the Gap Campaign Steering Committee, 2018; Commonwealth of Australia, 2018). The lack of progress indicates a problem in policy and implementation. This research explores the social determinants of Indigenous health, recognising the ongoing impact of colonisation, racism and discrimination, as well as the importance of culture, identity, kinship, connection to country, and the cycle of life-death-life. The social determinants of Indigenous health are explored alongside Indigenous rights, particularly the right to self-determination. Therefore, this research explores the extent to which rights and social determinants of Indigenous health are embedded and acted on within the CTG strategy in early childhood, and through implementation in two case studies.

1.2 Research Focus on Early Childhood

A healthy start in life gives children the chance to thrive and grow, and to make a positive contribution to the community (Irwin, Siddiqi, & Hertzman, 2007). Numerous studies by Hertzman and colleagues have shown that childhood experiences affect subsequent health status in profound and long-lasting ways (Hertzman & Boyce, 2010; Hertzman & Power, 2003; Hertzman & Weins, 1996; Hertzman & Williams, 2009). In the final report to the World Health Organization's Commission on the Social Determinants of Health, Irwin et al. (2007) reported that early life experiences influence learning, school success, economic participation, social citizenry and health. Studies by Emerson, Fox, and Smith (2015), Malekpour (2007) and O'Connell, Boat, and Warner (2015) all shown that children's early physical, social, emotional and cultural environments shape cognition, language, and social and emotional health and development. Arabena, Panozzo, and Ritte (2016) highlighted the importance of the first 1000 days of a child's life and have cited neuro-scientific evidence on the long-term consequences of stress on brain development. When a baby falls behind with their early development, they are much more likely to fall even further behind in later development, than to catch up (Arabena, 2014). Siddiqi, Hertzman, Irwin and Hertzman (2011) argued that if a window of opportunity for healthy child development is missed in the early years, then it becomes increasingly difficult to support the health of individuals and populations. The earlier work by Irwin et al. (2007) reviewed evidence showing how mental health/illness, obesity, heart disease, criminality, and literacy and numeracy are strongly affected by conditions of early childhood.

The barriers and enablers of healthy child development are complex and interconnected. The most important influences on child development begin in utero, and then continue within the family environment and relationships, the community where a child grows, and the type of early childhood development programs available and accessible (Wise, 2013). Research shows that "hazards to the developing child are not distributed equally across Indigenous and non-Indigenous groups" (p.6). In the 'Footprints in Time' longitudinal study on Australian Indigenous children, the Department of Social Services (2015) reported that Indigenous children experience, often as a result of disadvantage, much higher rates of major life events resulting in social and emotional difficulties, with research now showing detrimental long-term effects on development. These major events are any event that can have a substantial impact on well-being, including circumstances such as the death of a family member, financial stress, substance misuse and family separation (Wilkins & Warren, 2012). In the Western Australian Aboriginal Child Health Survey, (Zubrick et al., 2005) explained that children who experienced up to two major life events within 12 months had a 15 percent chance of developing social and emotional difficulties. This increased to 25 percent if children experienced three major life events, and 42 percent chance of social and emotional difficulties for children who experienced seven or more (Kikkawa, 2015).

Aboriginal and Torres Strait Islander children in Australia have specific and unique needs related to health and culture (Eicklelkamp, 2010). According to Zubrick et al. (2005) within Australian Aboriginal cultures, Aboriginal children represent a link with ancestry and are regarded as precious and central to Aboriginal society. They explain that Aboriginal children carry with them the hopes for the future. In a study by Priest, Thompson, Mackean, Baker, and Waters (2017), Aboriginal children themselves identified the importance of cultural activities such as face painting, dance, family and community gatherings, as well as identifying with the Aboriginal flag and country. The children recognised these activities promoted their Aboriginal identity, health and well-being.

Therefore, investment in early childhood is an important strategy for population health and health equity, and a range of other positive social outcomes. Hertzman's research has been vital in providing evidence on the need for governments to invest more in programs that support early child development and improvements in outcomes for children in the short term, and health over the long term (Hertzman & Power, 2003; Hertzman et al., 2010).

1.3 Closing the Gap Strategy

In 2007, the Council of Australian Government (COAG), together with Indigenous health bodies and the Aboriginal and Torres Strait Islander Social Justice Commissioner, committed to 'closing the gap' in life expectancy between Indigenous and non-Indigenous Australians (Pholi, Black, & Richards, 2009). As outlined by the Australian Human Rights Commission (2020), the strategy was a response to the 'Close the Gap' campaign, led by Australian Indigenous and non-Indigenous health bodies, non-government organisations and human rights organisations to advocate for closing the health and life expectancy gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians within a generation. Since its inception, the CTG strategy has enjoyed bipartisan government support and remains a high priority for Commonwealth, state and territory governments.

The CTG strategy is outlined within the National Indigenous Reform Agreement (NIRA). The NIRA was designed as a living document that links the National Agreements and National Partnerships through COAG that aim to close the gap in Indigenous disadvantage (Council of Australia Governments, 2009). It positioned the Australian government as a primary funder and driver of efforts to address health inequity and established roles, objectives, outcomes, outputs, performance measures and benchmarks for progress. In 2015 the target for enrolment in early childhood education was increased to 95% in response to strong progress in this sector (Commonwealth of Australia, 2016). The six targets of the CTG strategy are shown in Table 1.

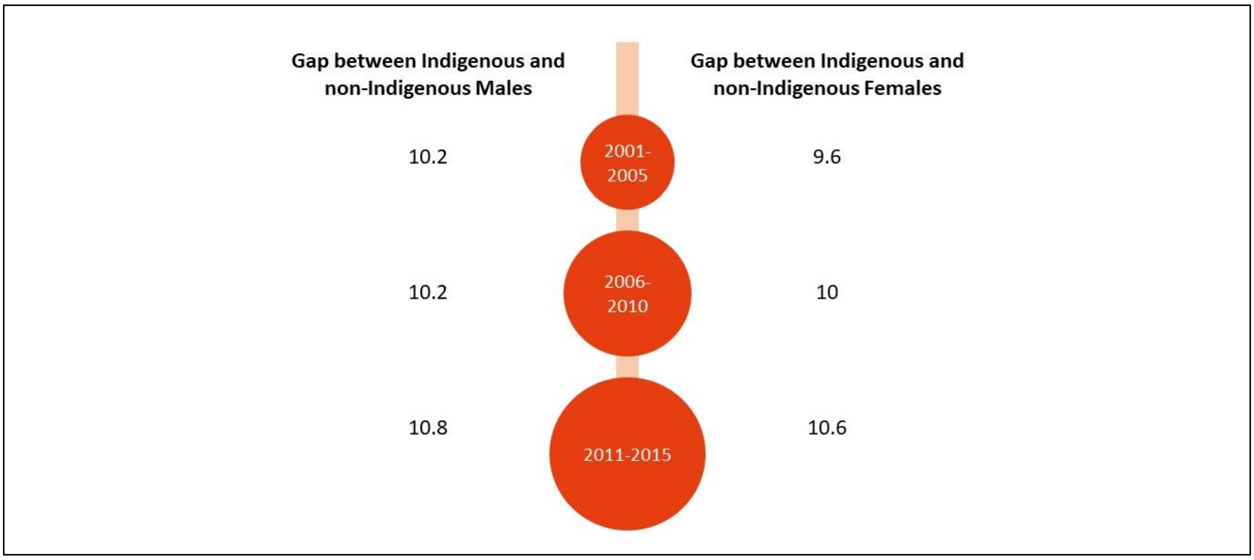
Table 1: Closing the Gap strategy targets 2018

Table 1: Closing the Gap Strategy Targets 2018
To close the gap in life expectancy within a generation (by 2031)
To halve the gap in mortality rates for Indigenous children under five within a decade (by 2018)
For 95% of all Indigenous four-year-olds to be enrolled in early childhood education by 2025
To halve the gap in reading, writing and numeracy achievements for children within a decade
To halve the gap for Indigenous students in year 12 attainment rates by 2020
To halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade

The NIRA identified important building blocks for CTG implementation: early childhood, schooling, health, economic participation, healthy homes, safe communities, and governance and leadership (Council of Australia Governments, 2009). These building blocks reflect the social determinants of health, and are all interconnected. Within each building block area there are numerous agreements through which programs are funded, monitored and outcomes reported back to COAG. In addition, there are policies outside of a direct CTG remit which also contribute to CTG targets. For example, policies in education can include programs that specifically target Aboriginal children but these policies can sit outside of the suite of CTG policies. According to the Close the Gap Campaign Steering Committee (2018) almost 6 billion dollars has been invested through the CTG strategy, including $564 million specifically in early childhood development with a focus on child and maternal health.

However, progress towards CTG targets has been mixed. In 2016, the Prime Minister's report claimed that "there has been encouraging progress, built on the combined efforts of successive governments, business, community and most importantly Aboriginal and Torres Strait Islander people themselves" (Commonwealth of Australia, 2016, p. 3). The Close the Gap Campaign Steering Committee (2019) reported that in fact, the target to close the gap in life expectancy was actually widening, rather than closing as shown in Figure 1.

Figure 1: Gap between Indigenous and non-Indigenous life expectancy (Close the Gap Campaign Steering Committee, 2019, p. 2) CC-BY-NC-SA



Similarly, it is reported that while the rate of child mortality has dropped during the time of the CTG strategy, so too has the child mortality rate for non-Indigenous children, and therefore this gap has also widened. For example, the Prime Minister's report in 2020 documented that the rate of child mortality for Aboriginal and Torres Strait Islander children is 2 times the rate of non-Indigenous children, 141 compared with 67 deaths per 100,000 for non-Indigenous children (Commonwealth of Australia, 2020). It was also noted that improvements in maternal health have not yet translated into improved health of children. In addition, some progress was recorded towards halving the gap in Indigenous children reading, writing and numeracy, but further improvements are required. Attendance in early childhood education for Indigenous children is high and recorded at 97.8 percent, but this has not improved school attendance with only 82 percent attendance recorded for Indigenous students compared to 92 percent for non-Indigenous students. The report acknowledged that school attendance is impacted by interrelated and complex factors including parent's education, employment, where families live, socioeconomic status and mobility (p.34), also recognised as social determinants of health.

In the shadow report on CTG program, the Close the Gap Campaign Steering Committee (2018) argued that while the CTG strategy has merit in attempting to address chronic disease, child and maternal health and other areas, there remains a lack of comprehensive action addressing the underlying causes of health inequality. They explained “lack of progress against [CTG] targets raise questions about whether there has been sufficient cross-portfolio commitment to Closing the Gap” (p.20).

The early criticism of the CTG strategy by Pholi et al. (2009) suggested that the Australian government’s approach to addressing health inequity reduces Aboriginal and Torres Strait Islander people to a set of indicators of deficits, monitored by government-set targets where evidence may not be reliable or valid. They explained that the targets measure what is “wrong”, what is “known” and how to “fix” Aboriginal people. Pholi et al (2009) argued that while there is some consideration of social determinants of health within the strategy, it lacks a focus on Aboriginal control, social and emotional wellbeing, addressing racism, or promoting culture. Following on from this, O'Donnell and MacDougall (2016) argued that the CTG strategy does not necessarily reflect the human rights approach of the founding ‘Close the Gap’ advocacy campaign. In addition, the Close the Gap Campaign Steering Committee (2018) suggested that it was somewhat ironic that initial National Indigenous Reform Agreement was agreed to without any significant Aboriginal and Torres Strait Islander engagement or partnership, and that the Australian government has seemed reluctant to invest in Aboriginal community controlled health services.

In 2020, after a decade of limited progress, a new Close the Gap Statement of Intent included a commitment with bipartisan support, to develop a comprehensive, long-term plan of action to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by 2030, and to ensure the full participation of Aboriginal and Torres Strait Islander peoples and representative bodies addressing their health needs. This is described as a “resetting” of the relationship between Australian governments and Aboriginal and Torres Strait Islander people (Australian Human Rights Commission, 2020).

1.4 Research context: Centre for Research Excellence in the Social Determinants of Health Equity

The NHMRC Centre for Research Excellence in the Social Determinants of Health Equity (CRE-HE) is a joint collaboration between Flinders University, Australian National University, University of Sydney, University of Ottawa and the Lowitja Institute, funded through the National Health and Medical Research Council (NHMRC) for 2015-2020. The overall purpose of the CRE-HE is to advance understanding of how government policy can work more effectively to address the social determinants of health, so as to improve health and promote the fair distribution of health in society (Flinders University, 2016). The aims of the CRE-HE are to:

- Understand how government policies can work more effectively to address the social determinants of health, so as to improve health and reduce health inequities.
- Increase understanding of the use of evidence in policy under conditions of multiple policy agendas and differences in power among groups;
- Build research capacity and undertake knowledge exchange so as to inform policy, generate political priority for health equity and improve the health of Australia's most disadvantaged peoples.

This research project sits within a CRE-HE policy implementation research case study on the CTG strategy. Research has shown that implementation of agreements across sectors under the CTG banner have not always resulted in action on social determinants (Comino, Knight, & Webster, 2012; Dwyer, Kelly, Willis, & Mackean, 2011; Osborne, Baum, & Brown, 2013; Ziersch, Gallaher, Baum, & Bentley, 2011), lacked a focus on self-determination (Tynan, 2013) and often missed the social determinants of Indigenous health (Carson, Dunbar, Chenhall, & Bailie, 2007). The CRE-HE broader research on 'Closing the Gap' aims to determine what mix of actors, values, institutional practices and systems makes for successful policy implementation to contribute to Aboriginal and Torres Strait Islander health equity in Australia.

1.5 Research Questions

This research addresses the following research questions:

1. To what extent are Indigenous rights prioritised and acted on within the 'Closing the Gap' strategy in early childhood?
2. To what extent are social determinants of Indigenous health recognised and acted on within the implementation of the 'Closing the Gap' strategy in early childhood?
3. How does the experience of the 'Closing the Gap' strategy in early childhood compare in Shepparton (Victoria) and Southern Adelaide (South Australia)?
4. To what extent has a decolonising approach to health equity been implemented through the 'Closing the Gap' strategy in early childhood?

1.6 Terminology

In this thesis, I use a variety of terminology related to Indigenous and Aboriginal and Torres Strait Islander people, policy and context. The word *Indigenous* relates to First Nations peoples globally. Many policies use the word Indigenous with references to Australia's Indigenous people. Therefore, the word *Indigenous* is used strategically in policy literature to reflect the global context and common inequities experienced by Indigenous people and communities in countries such as Australia, New Zealand, Canada and the United States of America. Some Australian policies and policy literature use the words *Aboriginal and Torres Strait Islander,* and when I discuss these policies and literature, I also use this terminology.

This research was conducted in two case studies where First Nations people were mostly Aboriginal. Shepparton is the home of the Yorta Yorta and Bangerang nations, and Southern Adelaide is the traditional land of the Kaurna people. Most research participants who identified as an Indigenous person referred to themselves as *Aboriginal*. Therefore, I use the word *Aboriginal* as it is consistent with the preference of local community. In addition, *Aboriginal* can be inclusive of all Aboriginal and Torres Strait Islander people and communities, as outlined in recommendations from the National Aboriginal Community Controlled Health Organisation (2006).

1.7 Thesis Structure

My thesis is structured in nine Chapters, including this introductory Chapter where I have explained the importance of early childhood as a determinant of the health and the context of the Australian government's CTG strategy.

The next chapter, Chapter 2, provides a review of the literature exploring early childhood, the social determinants of Indigenous health and policy. Key themes that emerged from the literature include colonisation past and present, the role of government in policy implementation, mainstream services, action on social determinants of Indigenous health, and Indigenous rights and self-determination. In this Chapter I consider how the literature showed that Indigenous peoples, health and rights are represented as policy problems and the impact this has on limiting policy goals, strategies and silencing other alternatives. I identify a gap in knowledge in the recognition and action on social determinants of Indigenous health and the implementation of policy in early childhood. A version of this Chapter has been published as a peer-reviewed article in the International Indigenous Policy Journal (George, Mackean, Baum, & Fisher, 2019).

In Chapter 3 I present methodology and methods, including the philosophical foundations for this research positioned at the interface of knowledge. I have drawn on an Aboriginal understanding of health that extends beyond a biomedical or western approach to knowledge. This holistic definition of health recognises the collective culture as a vital element of health and wellbeing for people, families and communities. Guided by principles of research at the interface of knowledge (mutual respect, reciprocity and discovery), I have embedded Indigenous knowledge in the analysis and discussion of policy implementation. From the outset, decolonising methodology was utilised in this research. This approach seeks to reimagine and rearticulate power, questioning and resisting colonial power that threatens Indigenous knowledge. I outline how I drew on critical social constructivism and an institutionalist theoretical framework and then applied this to policy analysis and two case studies. In this Chapter I include details on my research methods including community engagement, deep listening, semi-structured in-depth interviews, participant recruitment, data analysis, and the dissemination of findings. Finally, I discuss ethical considerations including the importance of researcher reflexivity.

Chapter 4 contains my analysis of policy documents relevant to the CTG strategy in early childhood. The policy analysis presented in this Chapter explores the concept of power and the ongoing nature of colonisation in the way that Indigenous rights and social determinants of Indigenous health are variously explicitly named and recognised, implied, or undermined and ignored in policy. In addition, examples of deficit problem representation consistent with the literature are identified to highlight silences and assumptions within policy documents.

In Chapter 5 I present the results of the case study of the policy implementation in early childhood from Shepparton, Victoria. In this Chapter, I provide an overview of the case study context and then present key themes that emerged from interview data. This includes the important role of an Aboriginal Community Controlled Health Organisation, the structural constraints of policy implementation, partnerships in policy implementation, policy not targeting the right gaps, the influence of policy actors on policy implementation, understanding self-determination and leadership, and the right to an Aboriginal childhood.

In Chapter 6, I present the results from the case study the policy implementation in early childhood from Southern Adelaide, South Australia. Consistent with the structure in the previous chapter, I provide an overview of the case study and then present key themes that emerged from interview data. This includes the rapid introduction of the CTG strategy, cuts to Aboriginal health, experience of consultation, the implications of a mainstream model for policy implementation, representations of power in policy implementation, understanding Aboriginal childhood, and a vision for policy implementation in Southern Adelaide.

Chapter 7, the Discussion, is devoted to discussing the key themes from the previous three Chapters and answering my research questions, with links to the literature. I explain that the CTG strategy can be characterised as a “Bandaid for a bullet wound” as it has not addressed the underlying causes of health inequity. I discuss policy implementation with regards to the recognition of Indigenous rights, and prioritising social determinants of Indigenous health. Then I identify approaches to policy implementation that are consistent with a rhetoric of “working with” Aboriginal people and I link this to processes of ongoing colonisation. I go on to discuss the way that an Aboriginal childhood is framed and the paternalistic and deficit discourse within the CTG strategy. I link this discussion with concepts of power and sovereignty. At the end of the Chapter I identify potential limitations of the study.

Chapter 8 is an overall conclusion, drawing upon the entire thesis where I provide a brief review of my contribution to knowledge and the implications for policy implementation.

In Chapter 9, I reflect on the decolonising research process, including my role as a non-Indigenous researcher. I draw on a weaving metaphor for research at the interface of knowledge proposed by Ryder et al. (2019) to unpack my standpoint and experiences of transformational unlearning.

CHAPTER 2: LITERATURE REVIEW

Having introduced the importance of early childhood and the Australian government's CTG strategy in the first Chapter, this Chapter outlines key concepts and reviews the current literature on social determinants of Indigenous health and policy. I begin by providing a background to the relevance of research on policy implementation and justification for focusing on social determinants. Key concepts, including health equity, Indigenous health inequity in Australia, social determinants of Indigenous health, and Indigenous rights, are outlined. The aim of the literature review is explained, along with the detailed search strategy. Findings from the literature review are presented and silences in the literature are discussed, positioning this research within the identified knowledge gaps. A version of this Chapter has undergone peer review and is published in the International Indigenous Policy Journal (George et al., 2019), see Appendix A. In this thesis, I recognise similar experiences of discrimination and inequality across high-income colonised countries and therefore I have focused the literature review on policy and social determinants of health in Australia, New Zealand, Canada and the United States of America. I acknowledge there are Indigenous peoples within these nations with shared experiences of inequity but with diverse cultural identities.

2.1 Background

According to Barrett (2004), policy implementation is an integral part of the policy process that is negotiated or modified depending on the influence of key stakeholders. Howlett, Ramesh, and Perl (2009) maintained that, institutions, actors, and the (tacit or explicit) ideas they hold influence the unfolding and outcomes of policy processes. Kay and Boxall (2015) clarified that policy makers have a strategic role to draw on lessons from implementation successes and failures, to ultimately design better policies, whereas institutions provide constraints and opportunities for policy implementation to occur. The ideas and influences of policy actors are reviewed in the literature and presented in this Chapter as they relate to social determinants of Indigenous health and Indigenous rights. Research by Stewart and Jarvie (2015) highlighted that it is essential to understand and learn from evaluations of policy implementation in order to improve the policy process.

Research has shown there are significant deficits in conceptualisation and implementation of social determinants of health in policy. Carter, Hooker, and Davey (2009) analysed the way that social determinants were acknowledged, audited, recommended or linked with aims in cancer policy. In their view, where social determinants were acknowledged, the naming of social determinants appeared to be ritualistic, “an incantation to be said before the policy or plan got on with the real business of reducing risk” (p.1451). They explained that inclusion of social determinants in a policy’s aims did not necessarily lead to recommendations for action. Another study by Phillips et al. (2016) explored social determinants in Australian child and youth health policies. They found that all of the policies analysed acknowledged social determinants to some extent, however strategies proposed to address these issues were few and limited in scope. They concluded that the broader determinants of health are either considered outside the scope of the health sector, or not a priority. A third study by Fisher et al. (2016) found that, although social determinants were generally acknowledged in Australian health policy documents, “policies generally did not recognise broader policy settings affecting the overall distribution of socioeconomic resources as determinants of health inequities” (p.553). In addition, key determinants of Indigenous health such as racism, cultural identify or strong community governance structures were very rarely identified in policies (Carson et al., 2007). The lack of effective strategies to address social determinants in policy is prevalent across colonised countries. Indigenous people globally have experienced health inequity in multiple forms, including lower life expectancy than non-Indigenous people. Policy research can advance understanding of more effective ways to address social determinants of health and promote the fair distribution of health in society.

2.1.1 Health Equity

Whitehead (1992) defined health inequities as differences in health that are unnecessary, avoidable, unfair and unjust. In Australia, people who are more socially disadvantaged (by income, employment status, ethnicity, education), have poorer health and shorter life expectancy (Australian Institute of Health and Welfare, 2010; Turrell, Stanley, de Looper, & Oldenburg, 2006). Clearly, health is influenced not only by individuals, but the social conditions in which they live, and the broader structures of society (Baum, 2015; Carson et al., 2007). The World Health Organization define social determinants of health as the conditions in which people are born, grow, live, work and age (Commission on Social Determinants of Health, 2008). To achieve equity in health, Whitehead and Dahlgren (2006) argued that no one should be disadvantaged from achieving their full health potential because of their social position or circumstance. A commitment to health equity therefore represents “the rights of people to have equitable access to services on the basis of need, and the resources, capacities and power they need to act upon the circumstances of their lives that determine their health” (Keleher & MacDougall, 2016, p. 12). According to the Commission on Social Determinants of Health (2008) policies that promote health equity should include actions to improve daily living conditions with a focus on people and communities who experience disadvantaged, balanced with actions to challenge and address the unequal distribution of power, money and resources for health across society.

2.1.2 Indigenous Health Inequity in Australia

Aboriginal and Torres Strait Islander culture in Australia is rich and diverse. For tens of thousands of years, Aboriginal and Torres Strait Islander people have shown resilience and strength, and experienced good health. Prior to colonisation, traditional healers were an integral part of society, and health was connected to life and kinship (Baum, 2015). According to Mitchell (2007) traditional societies were based on cooperation and relationships, and while people still experienced infectious disease, they were mild in comparison to epidemics post colonisation. Colonisation in Australia was characterised by the loss of life and land (Keleher & MacDougall, 2016). The loss of land disrupted a connection to country, negatively impacting physical, emotional, social and spiritual health for people and communities (Anderson, 1988). In addition, policies of segregation and assimilation have continued to impact social determinants of health and contributed to health inequity (Keleher & MacDougall, 2016). Much has been written about the ongoing impact of colonisation on health, the prevalence and detrimental effect of racism, and the national shame of health inequity (Eades, 2000; Saggers & Gray, 2007; Sherwood & Edwards, 2006). In the National Aboriginal and Torres Strait Islander Health Plan 2013-2023, the Australian Government recognises that “dispossession, interruption of culture and intergenerational trauma have significantly impacted on the health and wellbeing of Aboriginal and Torres Strait Islander people” (Commonwealth of Australia, 2013b, p. 8)

2.1.3 Social Determinants of Indigenous Health

The social determinants of Indigenous health include a focus on culture, family and community, and connection to country (Australian Institute of Health and Welfare, 2018; Carson et al., 2007). These determinants reflect an Aboriginal definition of health, as outlined by the National Aboriginal Community Controlled Health Organisation (2006), Aboriginal health is "not just the physical well-being of an individual but refers to the social, emotional, and cultural well-being of the whole community, in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community". In this study, social determinants of Indigenous health will be understood as the conditions in which Aboriginal people are born, grow, live, work and age (Commission on Social Determinants of Health, 2008), and culture, community and the cycle of life, death, life (Carson et al., 2007).

As an important determinant of health, culture is shared by Aboriginal and Torres Strait Islander people through social engagements (Venn, 2007), storytelling (Strang, 2000), music, dance and art (Allain, 2011; Dyer & Hunter, 2009; Neuenfeldt, 2008; Thompson & Connally, 2006), and participation in sport (Dinan-Thompson, Sellwood, & Carless, 2008). Aboriginal health is also inherently linked to a connection to the land (Kingsley, Townsend, Henderson-Wilson, & Bolam, 2013) and Aboriginal people have fought to preserve this connection (Weir, Stacey, & Youngetob, 2011). McIntyre-Tamwoy, Fuary, and Buhrich (2013) described this as a "deep, intimate relationship with the environment and country" (p.97). Pickerill (2009) explained that "country is multidimensional – it consists of people, animals, plants, Dreaming, underground, earth, soils, minerals and waters, surface water and air (p.68). The historical importance of country is described by Smith (2006) as 'footprints' of forebears that "leave a trace of previous moments…they represent the accretion of place through ancestral action and the ongoing presence of 'old people', the spirits of forebears to whom the living bear responsibilities" (p.225-226). For Aboriginal people, caring for country is an essential part of culture because environment and people's health co-exist and cannot be not separated (Pickerill, 2009).

The forced removal of Aboriginal people from their traditional lands has had on-going negative consequences and caused multi-generational trauma (Baum, 2015). Smith (2006) described a sense of loss that haunts Aboriginal people and calls for them to reconnect with country. He explained, "this urge to regain what has been 'lost' marks another aspect of diaspora identity, an underlying sense that those aspects of their selfhood experienced as lacking can, in the right circumstances, be restored to them, a process commonly described as 'healing" (p.229). Although this connection to the land has been disrupted by colonisation, it remains and integral part of Aboriginal health and well-being. It is clear that Aboriginal people hold strong positive values towards their environment and this is key component of identity, a sense of self, and culture (McIntyre-Tamwoy et al., 2013), and therefore a connection to country has high importance for social, cultural and spiritual wellbeing for Aboriginal people (Venn, 2007).

Racism is another determinant of health that affects mental and physical health (Sellers, Bonham, Neighbours, & Amell, 2006; Williams, Neighbours, & Jackson, 2003; Ziersch, Gallaher, et al., 2011). Paradies (2007) defined racism as a type of "oppression, which along with its opposite, privilege, is based on a range of social characteristics" (p.67). He explained that this oppression/privilege is systemic in society and is embodied in attitudes, beliefs, behaviours, laws, norms and practices. Research by Ziersch, Baum, and Bentley (2011) showed that racist assaults are an aspect of everyday life for Aboriginal people in Australia. Paradies (2007) said racism permeates the very fabric of contemporary Australian society. A systemic review and meta-analysis showed that racism was associated with poorer mental health (including depression, anxiety, and psychological stress), poorer general health and poorer physical health (Paradies et al., 2015).

2.1.4 Indigenous Rights

Taket (2012) argued that "the promotion, protection, restriction or violations of human rights have direct and indirect impacts on health and wellbeing, in the short, medium and long term" (p.75). The United Nations (1948) declared that people have a right to education, food and nutrition, and freedom from discrimination, and these are examples of a right to the social determinants of health. After decades of international attention on human rights, the United Nations adopted the 'Declaration on the Rights of Indigenous Peoples' in 2007 (United Nations, 2007). This recognised dignity, wellbeing and rights of the world's Indigenous people, in addition to basic human rights. The Declaration addressed both individual and collective rights, equality and freedom from discrimination, self-determination, and the maintenance and strengthening of Indigenous institutions (Healey, 2014). According to the Australian Human Rights Commission (2013) self-determination is a right for people to freely determine their political status and to pursue economic, social and cultural development. They clarified that this has particular application for Aboriginal and Torres Strait Islander people, as they exercise rights to meet social, cultural and economic needs. They stated that the loss of these rights is at the heart of Indigenous disadvantage and that "without self-determination it is not possible for

Indigenous Australians to fully overcome the legacy of colonisation and dispossession". Talbot and Verrinder (2014) described the Declaration as an important tool for advocacy on self-determination in Australia, even though it is a non-binding human rights instrument, has no status in the Australian legal system, and was not initially endorsed by the Australian government. Still, the declaration was described by Davis (2007) as an important development for Aboriginal and Torres Strait Islander people because the promotion of Indigenous rights opposes discrimination, colonisation and assimilation policies.

Controversially, Australia, New Zealand, Canada and the United States of America all initially voted against the adoption of the Declaration in 2007 (Talbot & Verrinder, 2014). Their opposition was focused on the term "self-determination" and the Australian Liberal Prime Minister at the time, John Howard, preferred a focus on "mainstream Australia" (Davis, 2007). Moreton-Robinson (2009a) argued that the Howard government moved away from Indigenous rights by focusing on "practical reconciliation" and mutual obligation contracts which monitored and disciplined Indigenous subjects (p.67). The policies and approaches of the Howard government years have been criticised as a return to principles of control and assimilation (McLoughlin, 2016). The Australian Human Rights Commission (2013) reported it was not until 2009 that a Labor government under Kevin Rudd pledged its support to the Declaration. McLoughlin (2016) argued that government policies implemented since the Howard era are yet to deliver promises of self-determination for Aboriginal people.

Thus while the United Nations' Declaration on of the Rights of Indigenous Peoples was a step towards Indigenous rights being realised, the political resistance to self-determination and failure to enact rights based legislation remains a barrier towards recognising the rights of Indigenous people, and addressing health inequity. Corntassel (2008) argued that political autonomy, governance, the environment, and community health are intrinsically linked. According to Tsey et al. (2010), when people in communities have greater control, they are likely to also have an increased ability to "manage disease, adopt healthier lifestyles and use health services more effectively" (p.170). This definition of self-determination as an Indigenous right that is essential for health, forms an important foundation for this research.

2.2 Literature Search Strategy

A scoping review of the literature allows synthesis of research evidence to map existing literature, summarise knowledge gaps, and make recommendations for future research (Peters et al., 2015). My search strategy was designed to identify literature addressing themes of Indigenous rights and social determinants of Indigenous health in policy relevant to policy in the last decade. My knowledge of Australian policy informed the search however, I also sought literature from comparable colonised countries; New Zealand, Canada and the United States, recognising that Indigenous people in these countries are subject to health inequities similar to those affecting Aboriginal and Torres Strait Islander people in Australia (Jackson Pulver et al., 2010). Therefore, the search strategy was not limited to Australian literature. In collaboration with a university librarian, subject categories and key search terms were identified and the search was initially run through these databases: Medline, Scopus, Informit, Proquest, and Australian Policy Online. Sources that were not in English were excluded. Only minor changes were made for each search depending on database structures. The search was originally run in March 2017. I found very little policy literature that focused on early childhood, indicating a gap in knowledge. To ensure the literature reviewed included additional relevant content, I repeated the search with a focus on early childhood removing the policy line from the search strategy, and the results are woven together in the findings section. The search strategy is shown in Table 2.

Table 2: Literature search categories and terms

Table 2: Literature search categories and terms	
Categories	Terms
Health	health* OR wellbeing OR "well-being"
Policy	policy OR policies OR "self determin*" OR decoloni* OR colonis* OR coloniz* OR assimilat* OR power* OR empower*
Social determinants of health	social* OR socio* OR determinant* OR marginali* OR poverty OR welfare OR cultur* OR accultural* OR psychosocial* OR family* OR families OR medicali* OR urbani* OR network* OR support OR literate OR literacy OR education* OR employment OR unemploy*
Indigenous	Indigenous OR Indigeneit* OR Aborigin* OR "Torres Strait*" OR "First Nation*" OR "First People*" OR Māori OR "American Indian*" OR Inuit* OR Métis
Children	“early childhood” OR child* OR infant

Alerts were created through the databases to identify any new records as they were published. Additional searches were run through the 'Closing the Gap' Clearinghouse website and Australian Indigenous HealthInfoNet to identify records that may have been missed by the larger databases. In order to search for further literature related to New Zealand, Canada and the United States, I included a targeted search within two relevant international policy journals, the International Indigenous Policy Journal and the Journal for Health Policy and Management. The peer review of the published journal article led to suggestions for additional sources from Canada which were included in the results. Records were excluded if they focused on program evaluation and outcomes rather than on policy; or if the literature focused on recommendations for policy in the future, rather than research on current policy. This narrowed the results to focus on policy and implementation rather than service evaluation. Grey literature from a variety of sources was included to add critical commentary and insight on policy implementation. All records were imported into NVivo11 qualitative analysis software and coded using thematic analysis.

2.2.1 Thematic Analysis

Analysis of the literature was both an inductive data driven approach to identify themes to emerge from the literature, and deductive where preconceived themes were sought from the literature. Dixon-Woods et al. (2005) explained this type of thematic analysis is appropriate for organising and summarising themes from the literature, to identify knowledge gaps and to structure research in response to specific research questions. Saks and Allsop (2007) note that a theoretical framework in a literature review provides structure for inductive analysis. Themes that were specifically sought from the literature included social determinants of Indigenous health, Indigenous rights and self-determination, and childhood. Other themes that emerged from the literature were colonisation, the role of government, and the provision of mainstream services. In addition, records were cross examined to explore whether themes were clustered in only certain types of literature (e.g. peer reviewed literature, government and non-government reports, policy audits, commentaries etc). This added depth to the analysis and ensured that themes were generated from a variety of source types.

2.3 Findings from the Literature Review

As expected, themes of social determinants of health, Indigenous rights and self-determination were discussed throughout the literature. Findings from the scoping review showed the ways that social determinants of Indigenous health and Indigenous rights are recognised in policy are contested. Much of the literature recognised social determinants of Indigenous health, especially the importance of culture. However, there was consensus in the literature that even when social determinants and rights are written into policy, this does not always result in action in these areas (Australian Institute of Health and Welfare, 2016; Cooper, 2011; Klein, 2015; Robertson et al. 2012; Smith, 2007).

In addition, the ongoing impact of colonisation on Indigenous peoples emerged as a central theme. The literature highlighted a contrast between a colonising, deficit-based approach to policy and one that stresses the value and strength of Indigenous cultures and individual or community capabilities (Carter et al., 2009; Klein, 2015; Sullivan, 2011). Even though cultural inheritance and maintenance may be acknowledged in policy as important for individuals (Australian Institute of Health and Welfare, 2016), Cooper (2011) argued that Indigenous expression of culture through language and use of traditional lands, “are not generally considered indicators of ‘progress’ by governments” (p.14). He went on to suggest that culture in this sense has been seen as a problem, rather than part of the solution, and therefore has been excluded from policy.

Other themes that emerged from the literature focused on the role of the government and on the provision of mainstream services for Indigenous people. Within these themes, the literature reviewed emphasised a need for commitment across governments and communities for equitable and meaningful collaboration and partnership, as opposed to tokenistic forms of engagement (Bishop, Vicary, Browne, & Guard, 2009; Browne et al., 2017; Cooper, 2011; Kelaher et al., 2015; Meo-Sewabu & Walsh-Tapiata, 2012; Victorian Council of Social Service, 2016).

2.3.1 Indigenous Children and the Social Determinants of Health

Multiple authors identified that the social determinants of health are interconnected and that there is a need to reduce the substantial and multiple sources of stress on Aboriginal children, families and communities (Bailie, Stevens, & McDonald, 2014; Guthridge et al., 2015; Johnston, Lea, & Carapetis, 2009). McNamara et al. (2018) explained that “the excess burden of morbidity experienced by Aboriginal and Torres Strait Islander infants and children is entirely preventable" (p.2) as it is linked to social determinants of health and discrimination. Edmond et al. (2018) explained the importance of child health checks for Aboriginal and Torres Strait Islander children where their physical health and development is assessed and monitored along with discussing housing, food security and access to support services. They found that even when Indigenous children less than 12 months old were identified as a priority for social and emotional well-being care, many children did not appear to be receiving services. Their research showed that as many as 25% of families had no follow up or referral even when issues relating to social determinants of health had been identified in the screening.

Geia, Hayes, and Usher (2011) argued that the health of Aboriginal and Torres Strait Islander families is compounded by colonisation, intergenerational trauma and the legacy of stolen generations. In addition, studies by Priest et al. (2012) and Macedo et al. (2019) identified that racism towards Aboriginal people begins in childhood. Multiple authors drew on an understanding of racism by Paradies (2006) where racism corresponds to a set a attitudes, behaviours and practices that maintain power imbalances across ethnic-racial groups. In children, racism leads to anxiety, depression, aggression, social and emotional difficulties, lower levels of self-esteem and other physical, social and emotional problems (Priest et al., 2013).

Education was identified as a key factor in the health of children (Guthridge et al., 2015) and that learning environments should provide opportunities for children to learn about their culture (Priest et al., 2012). This was seen as an essential way for children to develop a strong sense of identity, connection to country and kinship (Macedo, Smithers, Roberts, Paradies, et al., 2019), essential for the social and emotional well-being of Aboriginal children (Kickett-Tucker, 2009). A review by Priest et al. (2012) explained cultural identity as "children knowing and understanding who they were, and where they were from" (p.184). Both Priest et al. (2012) and Macedo, Smithers, Roberts, Haag, et al. (2019) recognised that cultural identity evokes sense of pride and can be a protective factor against racism.

2.3.2 Colonisation past and present

Colonisation was viewed by multiple authors as a determinant of the health of Indigenous people, having multiple, adverse impacts (Brown, 2009; Campbell et al., 2018; Klein, 2015; Lavoie, 2014; Lavoie & Dwyer, 2016; Munshi, Kurian, Morrison, & Morrison, 2016; Wilmot, 2018). Unal (2018) explained that colonisers to the United States of America drew on doctrines of discovery and conquest to dispossess Indigenous people from land and remove sovereign rights. Cooper (2011) argued that colonial policies that result in the dislocation of Indigenous people from their homelands prevent Indigenous self-determination, undermine economic and social development and fragment families, and are directly linked to the poor health of Indigenous children globally. Following on from this, he argued that Australian policies have assumed control of the lives of Aboriginal people, resulting in "increased feelings of frustration, disempowerment, stress and anxiety and the associated incidence of chronic illness" (p.11).

In addition, Black and McBean (2016) described colonisation as destructive, with far reaching consequences for Aboriginal people in Canada. Peer reviewed literature from both Australia (Bishop et al., 2009; Brown, 2009; Browne et al., 2017; Lindstedt, Moeller-Saxone, Black, Herrman, & Szwarc, 2017; Robertson et al., 2012; Stanley, 2008), and Canada (Cooke & McWhirter, 2011; Greenwood & de Leeuw, 2012; Mitchell & Macleod, 2014; Shewell, 2016), described the damage caused by past policies of segregation, marginalisation and assimilation and which were still impacting on the lives of children. One particularly damaging characteristic of colonisation described was the forced removal of Indigenous children from families in Australia, the United States, and Canada (Black & McBean, 2016; Brown, 2009; Hill, 2008; Lavoie, 2014; Mitchell & Macleod, 2014; Shewell, 2016; Unal, 2018). According to Menzies (2019) there were two basic, related beliefs driving the forced removal of Indigenous children in Australia: firstly, that Aboriginal children needed saving from a 'savage' culture, community and family; and secondly, that removing Indigenous children would enable them to become 'civilised' and benefit from a superior settler society. Menzies (2019) explained that racism was the central feature in the forced removal of children and "no other cultural group or children of other racial backgrounds were subjected to the same level of racial scrutiny and ultimately, forcibly removed from their families in the way that Indigenous Australians were treated within the child welfare system" (p.7). Bishop et al. (2009) argued that Aboriginal children are still removed from families in Australia, but in a more sophisticated manner through the welfare system, noting that while current policies are written to focus on "child welfare" rather than forced removal, Aboriginal children are “still removed at a rate over six times more than non-Aboriginal children” (p.113). Lindstedt et al. (2017) stated that in 2015 Aboriginal and Torres Strait Islander children were living in out of home care at a rate of 52.5 per 1000 children, compared to 8.1 per 1000 children for the total population, indicating that removal was 9 times more likely for Indigenous children. The trauma associated with the forced removal of children has significant impacts on social and emotional wellbeing and contributes to current inequities in health, education, employment, housing, and criminal justice (Menzies, 2019).

The grey literature from the non-government sector also recognised ongoing impacts of colonisation. Klein (2015) described Australian policies as paternalistic, directive, and deficit based. Smith (2007) argued coercion is a policy instrument to enable government control over Aboriginal people and this has disempowered Indigenous people since colonisation. She argued that “the history of Indigenous Affairs in Australia shows that coercion rarely leads to sustained positive outcomes. On the contrary, often it has led to unintended consequences that have exacerbated problems and created profound misery on the ground” (p.7). An example of “failed policy” (Russell, 2010) attributed to ongoing colonisation was the Australian government’s “Northern Territory Emergency Response” (Anderson, 2007; Cooper, 2011; Cox, 2011; Lawrence, 2013; Smith, 2007) of which, Brown (2009) stated that “developments in the Northern Territory demonstrate that governments are still willing to exercise strict and punitive controls over Aboriginal individuals and communities” (p.1563).

Black and McBean (2016) argued that decolonisation in policy would reflect a more holistic approach to addressing the health concerns of Indigenous communities. There were five sources that drew attention to decolonisation in policy through the Treaty of Waitangi in New Zealand, this included the three sources that focused on policy in New Zealand and two other comparative studies (Dwyer et al., 2014; Lavoie, Boulton, & Gervais, 2012; Meo-Sewabu & Walsh-Tapiata, 2012; Munshi et al., 2016; Ronald & Koea, 2013). Lavoie (2014) explained that New Zealand was the final British colony to be settled, with government committed to avoiding the complexity and violence experienced in other colonies, and that Māori people were able to exert their sovereign rights (Ronald & Koea, 2013). As a result, integration was prioritised over marginalisation or containment and this led to the Treaty of Waitangi. This Treaty enables Māori values and ideology to be incorporated into social and health policies more easily than in other colonised society without such a treaty. The Māori concept of whanau ora (family health) has become a priority for health services promoting a focus on well-being more aligned to an

Indigenous definition of health (Dwyer et al., 2014). The Treaty of Waitangi provides an example of policy that does not represent Indigenous people as the policy problem. While policy implications of the Treaty remain contested (Ronald & Koea, 2013), it has been shown to provide a framework for collaboration (Carter et al., 2009), because consultation with Māori on policy matters is required by law (Munshi et al., 2016). Ronald and Koea (2013) explained that "any discussion concerning the health of Māori in modern society must consider the historical, cultural and social context in which Māori have arrived in the 21st century" (p.173). Māori people have fought for their right to self-determination since the Treaty was first signed in 1840. Meo-Sewabu and Walsh-Tapiata (2012) highlighted that there are lessons to be learned from Māori advocates who have "determinedly reclaimed and revitalised many aspects of their culture in order to preserve and transfer these to future generations" (p.306). They argued that cultural preservation is essential, and policy must incorporate a commitment to human rights and an Indigenous concept of health and wellbeing. Unal (2018) described treaties with Indigenous people in the United States as a cornerstone of policy but that they have been limited in reach and time. These treaties do not carry the same weight as the New Zealand Treaty of Waitangi because implementation is discretionary and shaped by funding rather than community need.

The Canadian policy context is built upon Treaty obligations whereby the government has an obligation to assume responsibility for the health of First Nations people (Lavoie & Dwyer, 2016). In addition Canadian constitutional recognition acknowledges the rights of First Nations, Inuit and Métis, to self-government. Wilmot (2018) explained this provides a foundation for decolonisation with the potential for improving the cultural sensitivity of health care and inclusion of more holistic and collective approaches to health and well-being. Kelly (2011), Lavoie and Dwyer (2016) and Wilmot (2018) all recognised that there has been a shift in Canadian policy from assimilation towards advocacy and self-governance, especially in the province of British Columba. However Wilmot (2018) argued that the legacy of colonialism remains a barrier to implementing decolonising policy because First Nations people continue to be perceived as "inferior and exotic" and "health care for First Nations people has been seen as a separate, marginal matter" (p.13).

2.3.3 Role of Government

In addition to criticism of colonial policies and their enduring effects, there was also criticism of more contemporary policy implementation and the role of government, adding to understanding of how problem representations have come about. Unal (2018) explained Indigenous health policy has a “long, complicated and often turbulent history… resulting in complicated interactions between federal, state, tribal, and other programs with various funding sources and systems of governance” (p.267). Kelly (2011) attributed jurisdictional gaps and long-standing debate between levels of government in Canada to the uncoordinated and fragmented health system. Critique of policy in Australia by Cooper (2011) argued generally that policy created in “silos” leads to poorly coordinated objectives and outcomes across government departments. Cox (2011) suggested that Australian policies have been ineffective and not often evaluated. Kelaher et al. (2015) maintained that policy evaluations have concentrated on the achievement of defined outcomes, at the expense of process. More specifically, Sullivan (2011) described national Australian policies such as the ‘National Indigenous Reform Agreement’ as bound by “political shackles” (p.19). He argued that the structure of these agreements that tie federal and state governments to each other, has resulted in ‘solutions’ that cannot respond to local problems. Fisher et al. (2018) highlighted an exception to this in Australia in the National Aboriginal and Torres Strait Islander Health Plan. In this policy, community control and partnership between Indigenous leaders and the government was seen as a priority. This was in response to analysis of past policy (including the National Indigenous Reform Agreement) by Indigenous leadership where partnership had been inadequate. Fisher et al. (2018) argued that this leadership and advocacy was crucial in the successful integration of social determinants of Indigenous health into national health policy.

Smith (2007) noted that government has a role in creating broader complex policy processes that are reflected in the unnecessary multiplication of programs and onerous funding processes. She argued that governments have not recognised the “extent to which government funding arrangements have exacerbated community and organisational dysfunction and poor governance” (p.11). Hudson (2009) suggested that these funding complexities make accountability impossible, and that “fewer than half of the Aboriginal health services file annual reports or complete their financial reporting requirements” (p.1). In addition, accountability was described in the literature as primarily one-way where recipients of funding are accountable for the spending and outcomes. Dwyer et al. (2014) argued that tensions concerning accountability have deep sources which are consistent with the problematisation of Indigenous people. Wilmot (2018) agreed that reciprocal accountability would support collaboration and a transformation decolonising agenda. Other literature highlighted a call for longer-term funding (Anderson, 2007; Australian Institute of Health and Welfare, 2016; Cooper, 2011; Dwyer et al., 2014; Kelly, 2011; Lavoie & Dwyer, 2016) that would incorporate sustained and consistent effort across government (Victorian Council of Social Service, 2016) and reflect a stronger commitment to action on social determinants of health to address issues of health inequity. Campbell et al. (2018) argued that long term funding is essential for early childhood programs in Australia. Lowell et al (2015) argue that under resourcing is a serious threat to sustainable and successful implementation of appropriate services for women and children.

2.3.4 Mainstream Services

The literature described an expectation from Australian, New Zealand and Canadian governments that mainstream health services respond to the needs of Indigenous people (Brown, 2009; Browne et al., 2017; Ronald & Koea, 2013; Victorian Council of Social Service, 2016) and that Indigenous people would then use them (Cooke & McWhirter, 2011; Cooper, 2011; Klein, 2015; Sullivan, 2011). In the early childhood literature, Jongen, McCalman, Bainbridge, and Tsey (2014) argued that both Aboriginal controlled and mainstream services have an important role to play in providing services to children and families. However, Freeman et al. (2018) explained that the Aboriginal population in their research was less likely to access mainstream early childhood health services and that one of the barriers is “Aboriginal mothers fear of what may happen to their baby if they disclose any concerns, and a lack of trust in their health-care provider” (p.544).

In the broader policy literature Lavoie (2014) argued even when mainstream services in Canada adopt targeted strategies to meet needs of the Indigenous community, it can reflect a cheap, underfunded version of welfare, and not meet expectations of the community, or the organisations. In New Zealand, Ronald and Koea (2013) explained that Māori people had concerns that mainstream services offered superficial appeasement, or at worst appropriation, of traditional customs, protocol and culture. Lowell et al. (2015) outlined that even when cultural knowledge from Indigenous maternal health workers was “recognised and valued by others, it is often viewed as a means to meet the priorities of the mainstream health system more effectively rather than as a valuable tool to improve health and wellbeing in its own right (p.6). Unal (2018) described mainstream health services as a Western model of health care which excludes traditional health practices. In addition, when governments decide what is the most effective health care without considering Indigenous knowledge, beliefs, traditions or customs, it “undermines self-determination, self-government, and the sovereignty of [Indigenous] people” (Unal, 2018, p. 266).

The expectation that Indigenous health and well-being is best achieved by integrating people into mainstream services (Klein, 2015), is criticised by Sullivan (2011) as ‘normalisation’. On one hand, normalisation can reflect a commitment to equality whereby all people have equal access to services. On the other hand, the process of normalisation undermines the importance of diversity and cultural practices and doesn’t take account of how accessible services are to different groups. Sullivan (2011) and Lavoie (2014) both connected this process of normalisation to assimilation and Sullivan argued that current Australian policies reflect this type of normalisation. Cooper (2011) argued that requiring Aboriginal people to access mainstream services when it is the only option available, subjects them “to increased levels of government control, surveillance and intervention in the name of addressing disadvantage and community dysfunction” (p.19). This is another example of how Indigenous people are represented as a problem. Smith (2007) suggested that while people may have to access mainstream services, “Indigenous people will never leave their culture to one side; they will not be assimilated” (p.12). Despite access to mainstream services in health and education through the CTG strategy in Australia, there have been some improvements in Indigenous health but inequities between Aboriginal and Torres Strait Islander people and non-Indigenous people remain, leading Cooper (2011) to conclude that the model needs reassessment, and indicating a silence in policy on other alternatives such as community controlled health services.

2.3.5 Social Determinants of Indigenous Health in Policy

Action on the social determinants, including cultural determinants, were identified as essential components to improve child and family health in this review (Australian Institute of Health and Welfare, 2016; Black & McBean, 2016; Cooper, 2011; Klein, 2015; Lindstedt et al., 2017; Robertson et al., 2012; Smith, 2007; Sullivan, 2011).

Ronald and Koea (2013) described a Māori definition of health that is connected to relationships with one another, community and the land and, in their view, is consistent with global Indigenous orientation towards holistic views of health and well-being. Both the article by Browne et al. (2017), and the report by the Victorian Council of Social Service (2016) recognised a holistic view of health and the importance of the social determinants of Indigenous health. Browne et al. (2017) highlighted that even though an Aboriginal definition of health may be quoted in policy documents, it does not always lead to holistic approaches to health in policy implementation. Unal (2018) explained that United States federal government acts may have laid a foundation for wide-ranging community-based health approaches including social determinants of Indigenous health and self-determination but implementation is lacking and there has been no assurance of action on social determinants of Indigenous health. A specific example of policy that has recognised social determinants of Indigenous health is the Australian National Aboriginal and Torres Strait Islander Health Plan. Fisher et al. (2018) described the way that policy actors responded to a window of opportunity to challenge conventional problem definitions to place social determinants of Indigenous health at the centre of health policy for the first time. Their analysis showed that despite a commitment to partnership and collaboration this policy was unclear in implementation and was not fully funded. Considered overall, these findings suggest that biomedical or deficit-based representations of Indigenous people as the policy problem overpowers the evidence supporting action on social determinants of Indigenous health.

When Indigenous knowledge and understanding of health are identified in policy but not acted on, the position of “other” is maintained as interesting but not worthy of action. An example from the early childhood literature was the continuation of traditional birthing practices. Lowell et al. (2015) explained these practices can go against health department policy but are still highly regarded and valued by the Aboriginal community. In their study, Aboriginal health workers reported frustration that their “expertise is often not recognised, and opportunities to utilise their knowledge are limited (Lowell et al., 2015, p. 5). Wilmot (2018) argued that the devaluing of Indigenous knowledge in the health care system has had a negative impact on health and well-being. Even though there is evidence that Indigenous knowledges are devalued, much of the early childhood literature regards this knowledge as an essential component of programs working to improve the health of children and families (Campbell et al., 2018; Lowell et al., 2015). Greenwood and de Leeuw (2012) from Canada argued that “recognising multiple ways of knowing and being in the world is fundamental to effective research and effective health care practice, with and for Aboriginal people” (p.383).

2.3.6 Indigenous Rights and Self-Determination

There was consensus in the reviewed documents that the United Nations' Declaration on the Rights of Indigenous People' should call governments to account over the support of Indigenous rights in policy and practice. Black and McBean (2016) argued that the recognition of Indigenous rights and commitment to self-determination are essential for the health of Aboriginal people. However existing policies on Indigenous rights appear to be incompatible with the Declaration at best, or a violation of rights at worst (Australian Institute of Health and Welfare, 2016; Cooper, 2011; Klein, 2015; Meo-Sewabu & Walsh-Tapiata, 2012; Mitchell & Macleod, 2014; Shewell, 2016). Cooper (2011) argued that the Australian government's actions within current policy breech many articles of the Declaration which reflect control and "Indigenous rights to self-determination, participation in policy development and implementation, and the ability to practise and maintain their unique cultures" (p.2). Shewell (2016) suggested the initial resistance by Australia, New Zealand, Canada and the United States governments to adopt the Declaration reveals "an inherent, ideological aversion to collective rights" (p.188). Brown (2009) described self-determination as implemented in Australia as a "failed experiment" (p.1562). She argued in general terms, without referring to a specific content of policies, that the move to embrace self-determination in Australian policy was conceived without infrastructure or resources to ensure sustainability. Smith (2007) argued that successive Australian governments have fundamentally failed to invest in Indigenous self-governance despite successful and strength-based examples of Indigenous communities "establishing good governance" and thereby "securing important social, cultural and economic outcomes" (p.9). The limited implementation and lack of funding for the National Aboriginal and Torres Strait Islander health plan with culture in the centre of health policy is further evidence of the lack of action on policy that promotes social determinants of Indigenous health (Fisher et al. 2018). Lavoie and Dwyer (2016) highlighted that without a Treaty with Indigenous people in Australia, self-determination is not a priority for the Australian government and it may require constitutional reform to fully address issues of governance and health equity.

On balance, while the literature suggested that self-determination was lacking in policy, there were many examples in the literature where policy outlined forms of engagement between policy makers and Indigenous peoples, described in terms of consultation, collaboration, community engagement, partnership or participation (Australian Institute of Health and Welfare, 2016; Bishop et al., 2009; Kelaher et al., 2015; Meo-Sewabu & Walsh-Tapiata, 2012;

Robertson et al., 2012; Ronald & Koea, 2013; Sullivan, 2011; Thomas, 2014; Victorian Council of Social Service, 2016). Some considered Indigenous “voice” in policy as essential for improving health equity, especially given the history of marginalisation (Kelaher et al., 2015; Victorian Council of Social Service, 2016). However, this review found that the depth, quality and purpose of Indigenous engagement in policy is contested and not the same as a commitment to self-determination. Black and McBean (2016) described consultation as a primarily “Western approach to Indigenous involvement” (p.14) which actually disempowers Aboriginal people resulting in negative outcomes for health and the environment. For example, Anderson (2007) described past Australian policy as “paternalistic” rather than a true commitment to working collaboratively. Similarly Lavoie (2014) argued that few health services in Canada include Aboriginal input into decision making, service planning or design. Strategies described in the literature used to engage with Indigenous people and communities are varied (Thomas, 2014) and can be tokenistic (Kelaher et al., 2015). Consultation is a concept that appears to be understood differently by different parties (Australian Institute of Health and Welfare, 2016). Mitchell and Macleod (2014) argued there is a rhetoric of consultation but a lack of subsequent action. An example from Klein (2015) suggested that consultation has been “more to convince local people of the merit of preconceived policies and principles than to inform the policies themselves, and allow deliberation and community participation” (p.7). Fisher et al. (2018) also found that even when policy is driven by consultation and a strength-based approach, action on social determinants of Indigenous health is often left unimplemented or unfunded.

Another approach to policy described in the literature, which would alter the representation of Indigenous people and cultures to a strengths-based view, is the embedding of Indigenous knowledge into policy and action, described by Black and McBean (2016) as an important foundation for decolonisation and improving health. They proposed that the inclusion of Indigenous knowledge in policy ensures “the recognition of inherent rights, the ability of Indigenous communities to participate fully and meaningfully in decisions that affect their people, and the transition to self-determination” (p.7). They advocated for a bottom-up approach to policy whereby Indigenous knowledge is respected and sought out by policy makers, shifting the problem representation away from Indigenous people. Wilmot (2018) described the integration of knowledges as an overlapping of boundaries where two cultural worlds interface, are mutually identifiable and reinforced, but also interact. Respecting Indigenous knowledge in this way supports local Indigenous participation in policy making and implementation can move beyond tokenistic consultation (Kelaher et al., 2015; Klein, 2015; Mitchell & Macleod, 2014) and paternalistic approaches to policy design and action (Anderson, 2007).

2.3.7 Early Childhood Policy

Nine records included in the literature review discussed early childhood within the Australian 'Closing the Gap' policy context (Australian Institute of Health and Welfare, 2016; Brown, 2009; Browne et al., 2017; Commonwealth of Australia, 2012, 2013a; Cooper, 2011; Fisher et al., 2016; Phillips et al., 2016; Robertson et al., 2012; Thomas, 2014). However, Indigenous rights and self-determination were not discussed explicitly within the early childhood literature. In addition, understanding the role of children in Aboriginal communities, and other social determinants of Indigenous health, did not appear to be prioritised within policies for Indigenous children. In the Australian context, evidence is mounting that efforts to close the gap in Indigenous disadvantage is failing (Russell, 2010). The 2017 Prime Minister's report on progress in "Closing the Gap' showed that the Australian government is not on target to achieve its goal of halving the gap in mortality rates between Indigenous and non-Indigenous children under five by 2018 (Commonwealth of Australia, 2017). The Australian Human Rights Commission (2017) reported that "this lack of progress in such a critical health target is completely unacceptable and indicative of insufficient action… to address the underlying social determinants" (p.13).

The evaluation of the National Indigenous Early Childhood Development National Partnership Agreement by Thomas (2014) focused on antenatal care, youth sexual health, maternal and child health, and the establishment of 38 new Children and Family Centres (CFC). The intent of this policy was to ensure that Indigenous children are born and remain healthy, with children seen as central to Aboriginal society (Australian Institute of Health and Welfare, 2016), but there is little evidence within this evaluation, of the inclusion of Indigenous knowledge, or cultural understanding of the important role that children play in families and communities.

2.4 Synthesis of the Literature

The literature in this review showed barriers and limitations to recognising social determinants of Indigenous health and Indigenous rights in policy. The Treaty of Waitangi in New Zealand provided evidence of the way that Māori people have withstood the forces of colonisation and had this recognised in policy. The National Aboriginal and Torres Strait Islander Health Plan in Australia reframed policy problems and deficits and positioned culture at the centre of the policy. However, policy implementation has been inconsistent or tokenistic. The failure of policy action on social determinants of Indigenous health is not a result of a lack of advocacy and resistance to colonisation, rather it highlights the lack of Indigenous rights and sovereignty in policy which would support social determinants of Indigenous health.

The way that problems are framed and represented within policy, influences the way that some problem 'solutions' are actioned while other possibilities are ignored or avoided (Bacchi, 2009). Policies that are paternalistic, directive and deficit based (Klein, 2015) reflect a position of privilege and power held by policy makers or governments over their constituents. The policy focus on mainstream services for Indigenous people (Brown, 2009; Browne et al., 2017; Cooke & McWhirter, 2011; Cooper, 2011; Ronald & Koea, 2013; Unal, 2018) represents the problem as a failure of Indigenous people to fit in with dominant, white social norms and institutions. With a solution that focuses on normalisation (Sullivan, 2011), Indigenous people themselves and their cultures are represented as the problem. From the literature reviewed, this deficit discourse in policy was strongly criticised by Klein (2015) and Sullivan (2011) where Indigenous people and communities are represented as "other". The forced removal of Indigenous children was built upon an assumption of white superiority over Indigenous groups and the legacy and trauma of such policies continues today (Menzies, 2019). A worldview that sees Indigenous people and cultures as "other" is reflected in health care (Goodman et al., 2017) and in policy (Schofield & Gilroy, 2015). The exclusion of traditional healers from policy in the United States demonstrates the power and influence of a Western worldview and understanding of health to position Indigenous knowledge outside of health. Unal (2018) explained that the lack of integration of traditional healers into health policy and service provision as resulted in fear and distrust of government run services. The racism where Indigenous people are represented as "other" is also deeply engrained in society in colonial countries like Australia (Baum, 2015) and Canada (Elliott & De Leeuw, 2009) and experiences of racism begin in childhood (Macedo, Smithers, Roberts, Paradies, et al., 2019; Priest et al., 2012).

It is clear that both historical colonial policies, and ongoing policy failings predominantly represent Indigenous people as policy problems, which require government intervention to solve. The effects of this deficit approach is likely to reduce effectiveness of policy, because it silences the potential for policy actions focused on building resilience and strength within Indigenous cultures (Chandler & Lalonde, 1998; Victorian Health Promotion Foundation, 2011) which is an essential social determinant of Indigenous health. When considering the history of colonisation and the impact on Indigenous people, it becomes clear that this representation of Indigenous people as the problem has been a dominant theme in past policies (Brown, 2009), and the struggle for self-determination (Kelaher et al., 2015; Klein, 2015; Meo-Sewabu & Walsh-Tapiata, 2012; Mitchell & Macleod, 2014; Sullivan, 2011). Colonial policies of segregation, marginalisation and assimilation have had lasting effects on Indigenous people and the policy environment (Bishop et al., 2009; Brown, 2009; Browne et al., 2017; Cooke & McWhirter, 2011; Kelly, 2011; Mitchell & Macleod, 2014; Robertson et al., 2012; Shewell, 2016; Stanley, 2008; Unal, 2018; Wilmot, 2018). This colonial foundation supports the siloed structure of governments (Cooper, 2011; Sullivan, 2011) and ineffective policy (Cox, 2011). Historically, the dominance of a western-centric approach has restricted sharing and influence of Indigenous knowledge outside of Indigenous communities, elevating colonial powers to a superior position (Goodman et al., 2017; Schofield & Gilroy, 2015; Tuhiwai Smith, 2012; Wilmot, 2018). This power and ongoing nature of colonisation means the representation of Indigenous people as “other” or as the problem that needs to be fixed, continues into much current policy, without consideration of the strength and importance of Indigenous knowledge. Sherwood (2010) argued that denying Indigenous knowledge further exacerbates the pain and injury caused by colonisation. Even though the literature revealed that collaboration and consultation with Indigenous people is commonly mentioned in policy, the quality of this engagement is inconsistent, and a does not constitute self-determination (Black & McBean, 2016; Klein, 2015; Lavoie, 2014). The process of participation in policy was described as primarily “Western”, and one which continues to isolate or marginalise Indigenous people. The top-down examples of policy where governments hold power over Indigenous people, can result in implementation that does not respond to the needs or strengths of Indigenous people themselves. Government control over the lives of Indigenous people (Cooper, 2011), and use of coercion as a policy instrument (Smith, 2007) have a negative impact on health and well-being.

2.5 Addressing a Gap in Knowledge

Mitchell and Macleod (2014) maintain that policies have often been developed and implemented in ways that are contradictory to the worldviews of Aboriginal people. My analysis of the literature showed that these alternative perspectives and Indigenous knowledges are often missing from policy. For example, in the evaluation of the National Indigenous Early Childhood Development National Partnership Agreement by Thomas (2014) there is no reference to an understanding of a healthy Aboriginal childhood in context of an Aboriginal definition of health. These types of silences within policy require further analysis. In addition, the policy literature included in this review points to gaps and silences on Indigenous knowledge and an Aboriginal understanding of health, suggesting that that Indigenous rights are missing from policy in early childhood.

This review of the literature showed that policies represent colonial approaches to power and that, while self-determination may be included in policy rhetoric, implementation of this principle is inconsistent. The themes that emerged from the literature highlighted that colonisation in policy is ongoing. The structure of mainstream service provision in health, and encouragement of Indigenous people to use mainstream services was described as problematic for the health of Indigenous people, and restrictive of self-determination. The literature supported the important role of government in policy implementation but called for a stronger commitment to Indigenous rights. Collaboration across sectors was seen as an essential component in policy implementation, however policy actors face challenges working together. The inclusion of social determinants of health in policy has been researched by Carter et al. (2009), Fisher et al. (2016) and Phillips et al. (2016), but a specific analysis on social determinants of Indigenous health would add depth to this field of policy analysis. In addition, research on the realisation of Indigenous of rights in policy implementation would explore the ways in which rights have been written into policy but action has been limited (Cooper, 2011; Shewell, 2016; Smith, 2007).

Furthermore, a research focus on policy implementation related to early childhood is timely given the lack of progress to reach CTG policy targets in this area. Research that links policy implementation in early childhood with social determinants of Indigenous health, Indigenous rights and self-determination is a new contribution to knowledge.

CHAPTER 3: METHODOLOGY

In this Chapter, I outline the philosophical foundations of the research methodology and methods. Epistemological and theoretical perspectives are discussed and the research is positioned at the interface of knowledges, where western scientific based knowledge systems intersect with Indigenous ways of knowing, being and doing. I outline a decolonising approach, critical social constructivism, and the link to an institutionalist framework as key features of the research methodology. Four research questions are presented to address the knowledge gap on the implementation of the CTG strategy in early childhood:

1. To what extent are Indigenous rights prioritised and acted on within the 'Closing the Gap' strategy in early childhood?
2. To what extent are social determinants of Indigenous health recognised and acted on within the implementation of the 'Closing the Gap' strategy in early childhood?
3. How does the experience of the 'Closing the Gap' strategy in early childhood compare in Shepparton (Victoria) and Southern Adelaide (South Australia)?
4. To what extent has a decolonising approach to health equity been implemented through the 'Closing the Gap' strategy in early childhood?

After presenting the aim, objectives and research questions, I then explain my approach to policy analysis (including a focus on Indigenous rights), and the structure of this research as a comparative case study. Research methods, including community engagement, deep listening, semi-structured in-depth interviews, as well as the recruitment strategy, data analysis, and dissemination of findings, are detailed. Finally, I discuss ethical considerations including the importance of researcher reflexivity.

3.1 Philosophical foundations

Epistemology is concerned with theories of knowledge about the world and how knowledge is constructed (Denzin & Lincoln, 2017). Crotty (1998) argued that is important to outline an epistemological stance because it influences how research is conducted, interpreted and presented. This research is founded on an understanding and respect for Indigenous knowledges, described by Durie (2005) as dynamic, and based on collective and holistic principles, rather than individual or reductionist perspectives. This holistic worldview integrates the past, present and future and therefore Indigenous knowledge is ever-changing, balancing traditional and contemporary contexts (Sherwood, 2010). Indigenous knowledges reflect systems of knowledge that have common characteristics among different Indigenous peoples globally. For example, Durie's understanding of Indigenous knowledge from a Māori perspective is consistent with Aboriginal and Torres Strait Islander ways of knowing, being and doing. As described by Grenier (1998), Indigenous knowledge is shared and communicated orally and through culture. It is stored in "people's memories and activities and is expressed in stories, songs, folklore, proverbs, dances, myths, cultural values, beliefs, rituals, community laws, local language and taxonomy, agricultural practices, equipment, materials, plant species and animal breeds" (p.2). In Grenier's example, some of the ways in which knowledge is expressed relate to recognized social determinants of Indigenous health including connection to country and culture. Sherwood (2010) and Hart (2010) both described Indigenous knowledge as relational and communally oriented, founded on notions of respect, responsibility and reciprocity.

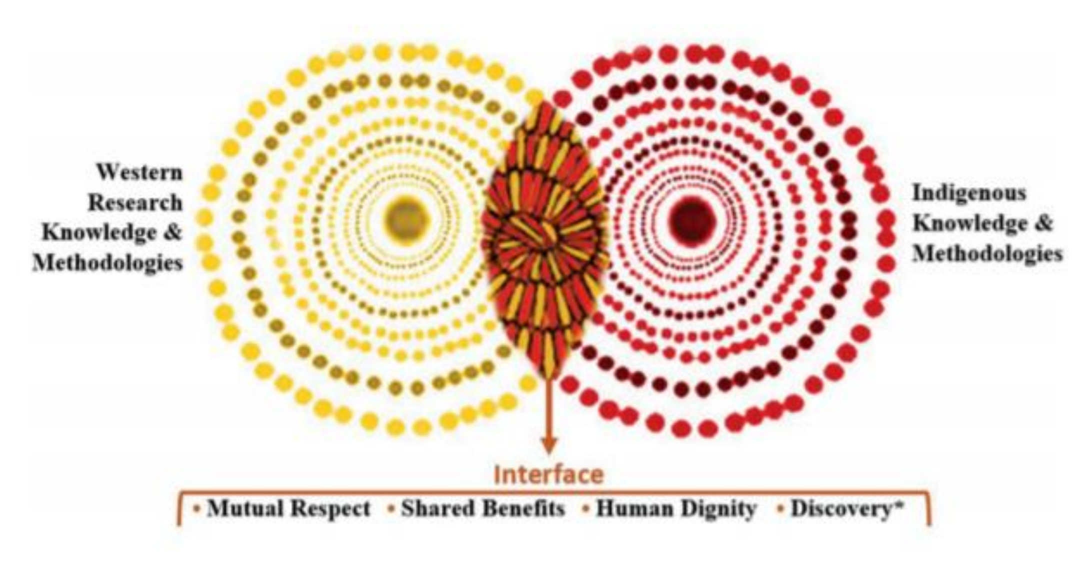
According to Sherwood (2010), Aboriginal people in Australia have made many attempts to share their ways of knowing, being and doing, and that while some non-Indigenous people have listened, many have not. Grieves (2009) explained that 'mainstream' society has historically been resistant to accepting that Aboriginal people have knowledge and solutions that promote health and well-being. This resistance continues despite growing awareness of the significance of Indigenous knowledges in healing and improving health and educational outcomes for Aboriginal and Torres Strait Islander people (Bessarab, 2015). Sherwood (2010) argues that a 'mainstream' failure to value Indigenous knowledge contributes to ongoing oppression and marginalisation, and to the current poor health status of Aboriginal people. Hernandez (2012) claims that Indigenous knowledge is fundamentally different to Western scientific knowledge and research based on a Western paradigm has often taken power and legitimacy away from Indigenous knowledge. Indigenous knowledge is important in understanding social determinants of Indigenous health and to promote policy implementation with action aligned to broader definitions of health and well-being.

The collective and holistic philosophy of Indigenous ways of knowing, being and doing is in contrast to positivist approaches that can isolate problems into controllable and scientifically measurable parameters (Ranzijn, McConnochie, & Nolan, 2009). Grenier (1998) explained that through Indigenous approaches, problems are examined in their entirety beyond controllable factors to incorporate social determinants of Indigenous health including culture, language, identity and belonging. The dominance of positivist approaches to knowledge has positioned Indigenous knowledge as “other”, which elevates colonial powers to a superior position (Goodman et al., 2017; Schofield & Gilroy, 2015; Tuhiwai Smith, 2012). However, Indigenous knowledge systems are essential for health and well-being. Sherwood (2010) argued that “denying their existence and importance, violates Indigenous peoples and further exacerbates the injuries meted out through colonization” (p.81). In the policy context, a positivist tendency is to treat policies as objective entities, based on rational decisions to address problems and produce desired outcomes (Bacchi & Goodwin, 2016). This linear approach can be challenged when underlying assumptions are critically analysed and considered through interpretivist approaches. Therefore there is scope for including and valuing Indigenous knowledge in research because of the contrast to positivist approaches, especially in the context of Indigenous health. Grenier (1998) argued “western approaches” alone are insufficient to respond to the complex social, economic, political and environmental challenges facing contemporary societies. Durie (2005) claimed that Indigenous knowledge had been considered as only applicable in the past, but that now there is a shift in research to explore Indigenous knowledge in contemporary times.

Different ways of knowing, in combination can provide richer and more diverse understanding of policy, and health and well-being (Semali & Kincheloe, 1999; Sherwood, 2010). Durie (2005) wrote, “Research at the interface aims to harness the energy from two systems of understanding in order to create new knowledge that can then be used to advance understanding in two worlds” (p.306). Durie’s key principles for learning and research at the intersection of knowledges are: mutual respect, shared benefits, human dignity and discovery. Hart (2010) challenged non-Indigenous researchers working with Indigenous people to think outside the dominant world view that favours positivist western knowledge, and to embrace Indigenous knowledge.

Ryder et al. (2019) developed a visual representation for the interface of knowledges (Figure 2). In this example, Ryder drew on her experience and knowledge of weaving to position research at the interface. As different knowledges are woven together, the two diverse knowledge systems do not just sit over the top of each other and overlap, they intertwine, and are woven together, to ensure structural integrity, consistent with the practice of basket weaving. Ryder et al. (2019) explained that when a basket is woven, reeds and other materials are wrapped and looped around a base structure, creating intersectional points. In research, these points represent the entwining of knowledges. "These intersectional points are representative of shared and respected knowledge, new discovery, and ways of understanding between Indigenous and Western knowledge systems" (p.7). An important feature of weaving outlined by Ryder et al. (2019) is the communal nature of the work which requires a collaborative approach, where people rarely work in isolation: so too was my experience conducting this research. Ryder's metaphor of research at the interface of knowledges shown in Figure 2, brought clarity to Durie's complex concept and became a vital tool for me to reflect on my standpoint (Chapter 9).

Figure 2: Visual representation of weaving methodology for 'research at the interface (Ryder et al 2019, p. 5)
Used with permission from Taylor & Francis



3.1.1 Decolonisation

From the outset, this research adopted decolonising methodology. Decolonisation is not necessarily a rejection of colonialism, rather it seeks to reimagine and rearticulate power, change and knowledge, as it questions and resists colonial relations of power that threaten Indigenous ways of being (Sium, Desai, & Ritskes, 2012). A decolonising approach recognises that colonisation is not just a fact of past history. Sherwood et al. (2015) claim that colonisation is a "current strategy to exclude Aboriginal ways of knowing, being and doing" (p.185). Sherwood (2009) explained that to embrace a decolonising approach in Australia, the impact of colonisation must be realised, and an understanding of history from both sides of the colonisation story could then inform political and social action. Importantly, decolonisation should not be seen solely as an Indigenous issue. Muller (2014) described decolonisation as an invitation to non-Indigenous people to understand and acknowledge the process of colonisation, and collaborate with Indigenous people. She wrote that decolonisation offers a pathway to honouring commitments to social justice and human rights. Decolonisation as broad methodological approach provided the foundation for me to explore Indigenous knowledge and Indigenous rights within policy within an early childhood context.

Decolonising approaches to research are not common practice in Australian universities or globally. As outlined by Tuhiwai Smith (2012), the history of Indigenous research shows that Indigenous people globally have continued to be colonised in the way they have been subjected to relentless study, exploitation, disrespectful experimentation – sometimes without permission – and representation of communities through a Western prejudice. In Australia, Aboriginal and Torres Strait Islander people have been over-researched without corresponding improvements in health (Bainbridge et al., 2015). Nakata (2007) argued that research devoid of Indigenous voices results in objectification. In these cases, the benefit of research may remain with the researchers, contributing to the power imbalances in research. It is not surprising that Indigenous people and communities over time, have learned to protect themselves from colonising research (Stephenson, McWilliam, & Thompson, 2003), and question the value of research notionally aiming to promote social change and improve the health status of Indigenous people (Bainbridge et al., 2015). Therefore, the embedding of Indigenous knowledge in this research is an important ethical consideration, discussed in more detail at the end of this Chapter.

McLaughlin and Whatman (2011) highlighted that a decolonising approach can create tension in academia where the use of Indigenous knowledge within institutions and the storage of Indigenous data can look similar to colonial ownership for colonial prosperity (Nakata, 2002). McLaughlin and Whatman (2011) described that a commitment to decolonisation although uncomfortable for some, should be regarded as power shifting and transformational. Therefore, a decolonisation approach within university research requires a deep sense of recognition of, and challenge to colonial forms of knowledge and research methodologies.

3.1.2 Critical Social Constructivism

This research takes a critical perspective. Crotty (1998) explained that a critical approach can highlight power structures, resistance to equity, and the way that power can harbor oppression, manipulation and other forms of injustice. This critical theory approach has been applied across disciplines, and is proven to be a useful approach when researching social determinants of Indigenous health and equity, particularly within a context of disempowerment and colonisation. West, Stewart, Foster, and Usher (2012) explained that critical Indigenous theorists uncover injustice and encourage debate to promote dissatisfaction with oppression. This exposes power imbalances and creates opportunity for transformation change for social justice (O'Mahony & Donnelly, 2010). Creswell (2009) argued that a critical approach is “concerned with empowering human beings to transcend the constraints placed on them by race, class and gender” (p.62), and this approach has been used extensively in exploring issues related to culture, race, ethnicity and social determinants of health (Anderson, 2006; O'Mahony & Donnelly, 2010; Stewart & Usher, 2007, 2010). This is supported by Hesse-Biber and Leavy (2011) who suggest that critical theory in qualitative research explores power and the way it influences experiences and understanding.

Social constructivism, put simply, accepts that truths are socially constructed and relative to time, place and culture (Baum, 2015). Social constructivism implies a critical approach because multiple meanings and interpretations of truth are examined (Burr, 2003). Patton (2002) argued a critical approach together with social constructivism can explore the way that “views of reality are socially constructed and culturally embedded, those views dominant at any time and place will service the interests and perspectives of those who exercise the most power in a particular culture” (p.100). In this research, the context provided by two case studies ensures that this critical approach is localised, grounded in specific meaning, traditions and customs, and community knowledge, as recommended by Denzin and Lincoln (2017). A similar philosophical approach was used successfully by Fitzgerald (2020) to explore mental health policy with two nested case studies. Through this approach, Fitzgerald identified the need to elevate a social view of health in public policy across multiple sectors to promote mental health. This example demonstrates the suitability of a critical social constructivist approach to policy research on social determinants of health.

3.1.3 Institutionalist Theoretical Framework

In studying the implementation of the CTG policy in an early childhood context, an institutionalist theoretical framework offered by Howlett et al. (2009) is helpful because through this framework, "it is possible to uncover how policy issues get on the agenda; how choices for addressing those issues are selected; how decisions on pursuing courses of action are taken; how efforts to implement the policy are organized and managed; and how assessments of what is working and what is not are produced and fed back into subsequent round or cycles of policy-making" (p.88). This framework aligns well with as social constructivist approach where views of research participants are a focus of inquiry to reveal the influence of actors, institutions and the ideas they hold as they influence the unfolding of policy processes (Creswell, 2007). In addition, Scott (2014) outlined that "an institutional perspective emphasizes the importance of the social context within which organisations operate… and attend to the larger drama rather than the individual player" (p.262).

3.2 Qualitative Methodology

I adopted a qualitative methodology for this research to explore Indigenous rights, social determinants of Indigenous health and decolonisation within policy documents as well the influence of actors, institutions and ideas on policy implementation relating to early childhood.

3.2.1 Aim, Objectives and Research Questions

The overall aim of this research is to understand the implementation of the CTG strategy in an early childhood context through analysis of two case studies, Shepparton and Southern Adelaide. I examined the extent to which implementation processes recognise and act on Indigenous rights, address social determinants of Indigenous health, and incorporate decolonising practices. The aims, objectives and associated research questions are collated in Table 3 and reflect themes of Indigenous rights, social determinants of Indigenous health, self-determination and decolonisation which have been discussed as key concepts and within the literature in previous chapters.

Table 3: Aims, objectives and research questions

Table 3: Aims, Objectives and Research Questions				
	Rights	Social Determinants	Self-determination	Decolonisation
Aims	To advance understanding of how and to what extent the implementation of CTG policies in early childhood have or have not realised Indigenous rights.	To develop understanding of how and why policy processes do or do not work effectively to improve health and wellbeing for Aboriginal and Torres Strait Islander peoples through action on the social determinants of Indigenous health.	To develop knowledge of the role of Aboriginal and Torres Strait Islander community actors and community-controlled organisations in determining policy implementation processes and outcomes.	Develop understanding of how institutional beliefs, values and practices of Australian governments/public agencies shape localised processes of policy implementation in ways that are colonising/decolonising or recognise Indigenous rights.
Objectives	To analyse CTG policy documents on early childhood during the study period to assess the extent to which they: recognise Indigenous rights; recognise social determinants of Indigenous health; and incorporate beliefs, goals and strategies consistent or inconsistent with principles of decolonisation.	To conduct qualitative research with members of Aboriginal communities in Southern Adelaide and Shepparton, and other relevant stakeholders, about implementation of CTG policy in early childhood and compare processes and experiences in each region	To understand experiences of CTG implementation in a community which has extensive community-controlled governance structures (Shepparton), and implementation in a community which doesn't have such structures in place (Southern Adelaide).	To identify key factors within CTG in early childhood policy implementation affecting the extent to which implementation processes: recognise Indigenous rights, recognise and take action on social determinants of Indigenous health, and incorporate decolonising practices.
Questions	1. To what extent are Indigenous rights prioritised and acted on within the 'Closing the Gap' strategy in early childhood?	2. To what extent are social determinants of Indigenous health recognised and acted on within the implementation of the 'Closing the Gap' strategy in early childhood?	3. How does the of the 'Closing the Gap' strategy in early childhood compare in Shepparton (Victoria) and Southern Adelaide (South Australia)?	4. To what extent has a decolonising approach to health equity been implemented through the 'Closing the Gap' strategy in early childhood?

3.2.2 Policy Analysis

Bacchi (2009) proposed an approach to analysing policy entitled “What’s the Problem Represented to Be?” (WPR). This approach critically analyses the values, beliefs and assumptions that underwrite policy through the way that ‘problems’ and ‘solutions’ are defined, represented and framed. Bacchi wrote that every policy constitutes a problematisation, a framing or representation of an issue that simultaneously implies ways of addressing that issue. For Bacchi, the way we frame and represent some things (and not others) reveals assumptions about certain truths. Bacchi’s analysis of assumptions is consistent with critical social constructivism which “cautions us to be ever suspicious of our assumptions about how the world appears to be” (Burr, 2003, p. 3). In this policy analysis, Bacchi’s WRP approach helped to uncover problematisations concerning Indigenous rights, social determinants of Indigenous health and decolonisation.

In addition, Taket (2012) argued that an Indigenous human rights framework maintains a focus on collective rights and the social determinants of Indigenous health, and can be used as a tool to highlight inequalities and inequities in health. Therefore, a focus on Indigenous rights defined within the ‘Declaration on the Rights of Indigenous Peoples’ (United Nations, 2007) was included within the policy analysis, to highlight issues including self-determination, and to consider the way that Indigenous rights have or have not been recognised and acted on in policy.

3.2.3 Case Study Model

I employed a case study model because it is appropriate to answer research questions on *how* and *why* policy has been implemented in certain ways (Yin, 2009) and this allowed me to explore to what extent Indigenous rights, social determinants of Indigenous health, and decolonisation are recognised and acted on within the CTG strategy in early childhood. Liamputtong (2013) defined the case study in qualitative research as “the study of a particular issue which is examined through one or more cases within a bounded system such as a setting or context” (p.95). Within this case study model, cases were purposefully chosen to be compared, in order to provide an in-depth understanding of policy implementation as it occurs within a defined place and community. Jones and Hocking (2015) explained that case studies may adopt a critical position, as well as an interpretivist perspective, and both positions are applicable in this study.

The two case studies in this research project are CTG policy in early childhood as implemented in Shepparton in Victoria, and Southern Adelaide, South Australia, and the ways Aboriginal communities in each regional have been affected by, or influenced implementation processes. These case studies were chosen during the planning of the NHMRC Centre for Research Excellence in the Social Determinants of Health Equity knowing that the CTG strategy in early childhood has been implemented in different ways, with different level of community engagement, local leadership and Aboriginal community control. The decision to focus on these two case studies was developed in consultation with key stakeholders, both Aboriginal and non-Indigenous in both locations. It was agreed that these two case studies provided a platform to explore the complexity of the implementation of the CTG in terms of different state governments, histories, and the role of community-led organisations in health and education. Evaluation of policy implementation in terms of health and education outcomes is beyond the scope of this research and would require alternative approaches.

3.2.3.1 Shepparton case study

Shepparton is a regional town within the Goulburn Valley, in the state of Victoria, approximately 180 kilometres north-northwest of Melbourne. Shepparton and the neighbouring town, Mooroopna straddle the Goulbourn River, known to the Yorta Yorta people as the Kaiela. The Yorta Yorta and Bangerang people are acknowledged as traditional owners within the Greater Shepparton region. The Greater Shepparton region covers an area of more than 240,000 km2 (Greater Shepparton City Council, n.d.) with a population of over 63,000 (Australian Bureau of Statistics, 2017). Approximately half the population live in the town of Shepparton (Greater Shepparton City Council, n.d.). Aboriginal and Torres Strait Islander people make up 3.4% of the population (Australian Bureau of Statistics, 2017).

Rumbalara Aboriginal Cooperative (hereafter, ‘Rumbalara’) is a community-controlled organisation that provides health and community services including early childhood within the Greater Shepparton community. Rumbalara has a proud history founded on advocacy and championing the rights of Aboriginal people (Rumbalara Aboriginal Cooperative, 2017). Shepparton also has Aboriginal specific services in early childhood. Lulla’s Children and Family Centre (hereafter, ‘Lulla’s’) is an Multi-Functional Aboriginal Child Care Centre, managed by the community and funded to meet educational, social and developmental needs of Aboriginal children (Victorian Aboriginal Education Association Inc, 2012). Specifically, Lulla’s aims to give the region’s Aboriginal children the best start in life, provide support to families, and celebrate

Indigenous culture.

3.2.3.2 Southern Adelaide case study

Southern Adelaide is a metropolitan region spread over approximately 570 square kilometres with a growing population of approximately 263,000 (across the Marion and Onkaparinga local government areas), where 1.5% identify as Aboriginal or Torres Strait Islander (Australian Bureau of Statistics, 2019). The Kaurna people are acknowledged as traditional owners of the Adelaide plains, including the Southern Adelaide region. There is no local Aboriginal community-controlled health organisation specifically for the Southern Adelaide region. However, 'Nunkuwarrin Yunti' is an Aboriginal controlled health services based in the city of Adelaide providing some services in the southern area. There are no early childhood services provided by Aboriginal controlled services in the Southern Adelaide region. Taikurrendi Children and Family Centre, located in the southern suburb of Christies Beach, is a universally accessible children's centre provided through the state Department of Education, with a focus on supporting Aboriginal families.

3.3 Research Methods

In this section I describe my research methods and analysis. I begin by providing an overview of policy analysis based on Bacchi's approach to problem representation (Bacchi, 2009). I then outline my approach to community engagement in both case studies including a formal partnership with Rumbalara in Shepparton and participation in the Joining Hands and Mind Network in Southern Adelaide. I go on to discuss the importance of 'deep listening' consistent with embedding Indigenous knowledge and decolonising methodology. A detailed description of the case study method is provided, including interviews, participant recruitment, inclusion and exclusion criteria, consent and confidentiality. Then I describe the analysis of the research findings including workshops with participants and the dissemination of results. Finally, ethical considerations are detailed, including the importance of respecting and embedding Indigenous knowledge, peer mentoring and researcher reflexivity.

3.3.1 Analysing Policy Documents

In a decade of the CTG strategy, there have been two iterations of policy which reflect changes in government from a Labor led era (Rudd-Gillard-Rudd 2007-2013), to the Coalition (Liberal and National) era (Abbott-Turnbull-Morrison 2013-2018). This research examines policy across both iterations and cover the first decade of the CTG strategy, 2008-2018. Numerous policies have contributed to the CTG strategy in early childhood over this period, both directly and indirectly. Policies relevant to early childhood within the CTG strategy consisted of:

a) Policies specifically established with CTG targets and linked to the National Indigenous Reform Agreement
b) Broader policies in health and education, recognised by government as contributing to achieving the early childhood CTG targets

A total of 12 policy documents from both of these categories were accessed from Australian government websites for analysis. This included policies from both iterations of the CTG strategy, documents directly linked to the NIRA and the CTG targets, as well as broader policy documents from education and health through which CTG targets are pursued.

Table 4: Closing the Gap policy documents relevant to early childhood

Table 4: CTG policy documents relevant to early childhood	
CTG 2008-2013	
#	Policy Title
1.	National Indigenous Reform Agreement (Closing the Gap) 2011
2.	National Partnership Agreement on Indigenous Early Childhood Development (2009 -14)
3.	National Partnership Agreement on Early Childhood Education
4.	National Aboriginal and Torres Strait Islander Health Plan 2013-23 (NATSIHP)
5.	National Education Agreement
6.	Investing in the Early Years – A National Early Childhood Development strategy
CTG 2013-2016	
7.	Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 – (IP-NATSIHP)
8.	National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families
9.	National Aboriginal and Torres Strait Islander Education Strategy (signed 2015)
10.	National Partnership Agreement on Universal Access to Early Childhood Education 2016 and 2017
11.	National Quality Agenda for Early Childhood Education and Care
12.	Indigenous Advancement Strategy – Grant Guidelines (IAS)

Policy documents were accessed online and saved as a pdf file, then all 12 policy documents were coded using NVivo 11 software.

3.3.1.1 What's the problem represented to be' approach?

According to (Bacchi, 2009), the 'What's the problem represented to be' approach has six key questions:

1. What's the problem represented to be, in a specific policy?
2. What presuppositions or assumptions underlie this representation of the 'problem'?
3. How has this representation of the 'problem' come about?
4. What is left unproblematic in this problem representation? Where are the silences?
5. What effects are produced by this representation of the 'problem'?
6. How/where has this representation of the 'problem' been produced, disseminated and defended?

The first question was crucial in identifying how a problem has been constructed. This question was used to code aims and goals of policies and whether Indigenous rights and social determinants of Indigenous health were explicitly embedded into proposed strategies, whether they were implied, or ignored. Questions 2-4 probed the context of problems, assumptions, what is missing, and what other solutions may be proposed. In addition, the institutionalist theoretical framework focus on the roles of actors, institutions and ideas (Howlett et al., 2009), was considered specifically within each question. These roles and ideas were coded within policy aims and objectives as well as proposed outcomes and measures. A coding framework emerged during the document analysis and is described in detail in the policy analysis Chapter. Finally, questions 5 and 6 were embedded in the case study analysis exploring how the CTG policy has been implemented in terms of early childhood in Shepparton and Southern Adelaide.

3.3.2 Community Engagement in Shepparton

Echo-Hawk (2011) suggested that partnerships in research can fall apart without participation that ensures Indigenous perspectives. Nayar and Stanley (2015) explained that researchers should demonstrate sensitivity when entering a new field of research and that prolonged engagement and discussion with cultural advisors supports cultural safety. In addition, community engagement provided opportunities to build mutual respect and acts of reciprocity, consistent with principles of research at the interface of knowledge (Durie, 2005). Therefore, community engagement within each case study was pursued and prioritised in the early stages of this research project. This began under supervision, and with introductions from supervisor Associate Professor Tamara Mackean, an Aboriginal academic and public health medicine physician, so that relationships with key people in both case studies were fostered to serve as a sounding board and to seek advice. This supervision played an important role in advising on research design and methods. As a result, community engagement was appropriately tailored for each case study to reflect the differing communities and contexts of Shepparton and Southern Adelaide.

3.3.2.1 Visiting Shepparton

I first visited Shepparton in August 2016 to meet with key stakeholders and discuss ideas for this research project. Conversations with policy actors influenced the direction of the project and focus on early childhood. My visit built on a connection with Rumbalara, established by the research team in the previous year. An important outcome from this visit was an invitation to, and acceptance from, of a key member of the Rumbalara research committee to become an associate investigator in the research, and be named as such in the ethics application for Goulburn Valley Health.

My second visit to Shepparton in April 2017 allowed me to foster stronger relationships with key staff at Rumbalara. In the time since my previous visit, there had been a change in leadership and it was important for the research team, including my research supervisors to meet with the new chief executive officer, to discuss opportunities for working together, and to begin to plan for data collection. This included introductions with senior managers, and a meeting with two members of the Rumbalara research committee to review the proposed interview guide and discuss potential changes to interview questions. At this visit, I was invited beyond the Rumbalara corporate services (in Shepparton), to visit the original site and home of the current Rumbalara medical and community services in the neighbouring town of Mooroopna. Through contacts made on the visit to Mooroopna, I received an invitation to connect with the Rumbalara Football and Netball Club.

So, with great enthusiasm, I “rocked up” to netball training on a Thursday night. As an experienced netballer myself, I took great joy in facilitating training for 3 teams, and joining in where I could. After training, I shared a meal at the football club with community members. The following day when I went back to connecting with people to talk about the research project, I was met with comments such as “I saw you at netball, make a time to chat with me when you come back next time”. This connection to community through sport provided an important reciprocal benefit to the research and is discussed in detail in the Chapter 9.

On my third visit to Shepparton with one of my PhD supervisors, we were taken on a historical and cultural tour of the Rumbalara site at Mooroopna. Details of this experience are included in the Shepparton results Chapter and my reflection Chapter. I visited the Rumbalara netball club again in 2018 and 2019 where I have spent time with community leaders as well as facilitating netball training for multiple teams. Up until the completion of this thesis, I have visited Shepparton five times. I was unable to return to Shepparton in 2020 at the end of the project due to travel restrictions in place during the Covid-19 pandemic. I plan to return upon the completion of my research to further disseminate findings and explore opportunities for further research.

3.3.2.2. Partnership with Rumbalara Aboriginal Cooperative (Rumbalara)

In the early stages of this research, Rumbalara was approached to be a partner in this project. Researchers from Flinders University and Rumbalara agreed to work together according to the following principles:

- *Reciprocity and respect***:** To practice reciprocity and mutual respect applying concepts of two-way learning, ngapartji ngapartji (exchange), and interface of knowledge systems.
- *A strengths-based approach and empowerment*: To recognise and seek to promote cultural, collective and individual strengths of Aboriginal and Torres Strait Islander peoples; challenge deficit-based views in research or policy; and supports empowerment of Aboriginal communities and individuals.
- *Recognition of social determinants of Indigenous health***:** To draw on knowledges and evidence of social, economic and cultural factors that affect the health and wellbeing of Indigenous peoples, including adverse impacts of colonising processes and racism, and positive health benefits associated with strong culture and self-determination.
- *A holistic view of health***:** To respect Aboriginal peoples' knowledge and understandings of health and healing.
- *Health equity:* To recognise Aboriginal peoples' equal rights to the enjoyment of the highest attainable standard of physical and mental health; and seek to promote equality of health status between Aboriginal Australians and non-Indigenous Australians.
- *Capacity building***:** to contribute to capacity building within, and relevant to the respective needs of, both partner organisations.

As partners, we agreed to ways of working together regarding governance, communication, and processes of collaboration. In action, this meant actively maintaining the relationship with Rumbalara from a distance. I called, sent text messages and emails to key contacts at Rumbalara throughout my PhD to build and support the partnership formally and informally. Every time I visited Shepparton I met with the members of the leadership team at Rumbalara to discuss and then review the formal partnership but I also shared lunches, coffee breaks and information conversation as I built trust and rapport with staff. Rumbalara staff provided advice on participant recruitment, data collection and data analysis.

In April 2019, four staff including the Chief Executive Officer from Rumbalara, visited Flinders University to discuss findings of the research of the CRE-HE on Closing the Gap policy generally, and specifically on the implementation of the CTG strategy in early childhood. We openly discussed different interpretations of ideas, including potential implications for research findings. This included discussion on a submitted conference abstract at the Ngar-wu Wanyarra Aboriginal and Torres Strait Islander Health Conference 2019. However, in the lead up to the conference (October 2019), there was an unexpected changed in senior leadership at Rumbalara and therefore we decided to withdraw from the conference. From my perspective, the partnership was more important than speaking at one conference, and we will explore other opportunities to disseminate findings to the region, at a time that is suitable for all interested parties. In addition to formal research meetings, we spent time together to share ideas, reflections and food. Both formal and informal conversations influenced my understanding of self-determination and the role of Aboriginal Community Controlled Health Organisations in policy implementation.

3.3.3 Community engagement in Southern Adelaide

In Southern Adelaide, where I live, there was no Aboriginal Community Controlled Health Organisation locally to establish a relationship or partnership with. Community engagement focused on government and non-government agencies providing services to members of the Aboriginal community within the region, and participating in community activities and initiatives beginning in 2016 and continuing into 2020. Some of the community engagement began through introductions from my supervisors but as a member of the Southern Adelaide community myself, I was able to connect with local services and community members easily. I already knew some of the key stakeholders through previous community work, local schools and sporting clubs.

3.3.3.1 Joining Hands and Minds Network

I was invited to attend and participate in the Joining Hands and Minds Network, which is a network for Aboriginal and non-Indigenous people in the Southern Adelaide region to build relationships, share resources and work in collaboration with one another (Joining Hands and Minds, 2019). This network originated from a task group in 2007 in response to consultation with the Southern Aboriginal Workers Network, the Southern Elders Group and Southern Primary Health (Joining Hands and Minds, 2012). Members represent a range of services and sectors, both government and non-government. The network meets monthly to provide service updates and coordinate events. I joined this network and in 2017, on the tenth anniversary of Joining Hands and Minds, members sought support to revise their formal commitments and action plan. I formed part of a team who collated consultation feedback which celebrated the longevity of the network and collective passion for reconciliation.

Key events for Joining Hands and Minds every year is a Reconciliation Week event and a NAIDOC week march. National Reconciliation Week occurs from the 27th May to the 3rd June. Each year Joining Hands and Minds organise a public event with live music, food, activities for children and many organisations provide a stall. In 2017 the event coincided with an education day and there were more than 1000 in attendance as shown in Figure 3.

Figure 3: Reconciliation week event 2017, Ramsay Place, Southern Adelaide case study (Photo by Emma George)

In addition, NAIDOC Week (National Aborigines and Islanders Day Observance Committee week) is held in July every year to celebrate the history, culture and achievements of Aboriginal and Torres Strait Islander people. In Southern Adelaide there is a march where children from local schools, along with community members walk along the road down to the beach, as shown in Figure 4. As a member of Joining Hands and Minds I have been a marshal at this annual event and stay for the day to support local agencies serving the community.

Figure 4: NAIDOC week March 2019, Christies Beach, Southern Adelaide case study (Photo by Emma George)

Updates on the research were provided to the community at Joining Hands and Minds meetings.

3.3.4 Deep Listening

Consistent with research at the interface of knowledge where Indigenous knowledge is respected and valued, ‘Deep Listening’ is a method that supports research reflexivity and understanding of complex concepts. In the language of the Ngangikurrungkurr people, Dadirri is a method of inner, deep listening and quiet, still awareness (Ungunmerr-Baumann 2002, cited in West et al., 2012). Atkinson (2002) explained that this practice is applicable in many Indigenous groups in Australia as “a process of listening, reflecting, observing the feelings and actions, reflecting and learning, and in the cyclic process, re-listening at deeper and deeper levels of understanding and knowledge-building” (p.19). Listening extends beyond a dialogue or interview, to shared experiences and connections, and deeper understanding of speech and feelings in context of time and place. Therefore, I learned to be more mindful and observant during community engagement and informal conversations and documented my reflections on the process as well as the findings. This practice is consistent with principles of mutual respect, shared benefits, human dignity and discovery (Durie, 2005). Therefore, Dadirri was a method for data collection and critical analysis in both case studies. My reflection on deep listening is included in Chapter 9.

3.3.5 Data Collection

Data were gathered through in-depth, semi-structured interviews with policy actors in both case studies. In addition, I spent time in each case study visiting key places. I walked along rivers, sat at lakes, marched along the streets and kept field notes on my observations of what I saw but also what I felt. Workshops were facilitated in both case studies in 2018 to present preliminary analysis of the data and seek feedback and input from research participants. A final workshop was conducted in Southern Adelaide in 2019 to discuss the overall results from both case studies and to seek feedback on opportunities for disseminating results with local communities. The shared analysis enhanced my depth of understanding of key concepts, deep listening and acceptance of Indigenous knowledge, consistent with the practice of Dadirri (West et al., 2012). In all workshops, participants and researchers established an environment of trust so that all views were considered with equal value and all knowledges were respected. Rapport between participants, who were often known to each other, and trust extended to the research team enabled open, honest and respectful communication.

3.3.5.1 Interviews

20 people in Shepparton and 23 people in Southern Adelaide were invited to participate in an in-depth, semi-structured interview. 16 people in each case study agreed to participate. Interviews lasted between approximately 60 and 90 minutes, conducted at a time and in a private location convenient to the participant. This included, offices or a room within a public or office building, or a quiet café. One interview was conducted over the phone at the participant's request. The interview guide (Appendix B) included a range of questions but the semi-structured design of the interviews ensured that I was able to respond to the context and experience of participants Interview questions focused on the work of the participant's organisation and the implementation of the CTG strategy in the early childhood context, partnerships with other services or departments, social determinants of Indigenous health, Indigenous rights and self-determination. Interviews were audio-recorded and transcribed verbatim.

3.3.6 Participant Recruitment

Organisations from the health and education sectors involved in the implementation of CTG in an early childhood context were identified to assist recruitment to the study. Community engagement supported the recruitment process as I was able to identify additional service providers and act on recommendations on who to invite to participate from discussion at community events and meetings. Potential participants were emailed an Introductory Letter (Appendix C) and a ‘snowballing’ method was also used to ask individuals (whether or not they chose to participate in the research) if they were willing, to nominate and provide contact details for other people as possible participants, whom they believed had skills, knowledge or experience relevant to the research. These people were then also approached as possible participants.

In all cases, accompanying the Introductory Letter, an Information Sheet (Appendix D) and Consent Forms (Appendix E) were provided to the person at the initial point of contact, either in hard copy delivered personally, or as an email attachment. Those who were willing to participate were able to indicate this by completing and returning a Consent Form to a member of the research team, or by stating their willingness to participate in a return email, or verbally to a member of the research team. In some cases, where specific circumstances were appropriate, initial contact was made with a prospective participant by phone or in person, at which point the Introductory Letter was used as the basis for introducing the research verbally. At that point, more information was offered, and a copy of the Introductory Letter, Information Sheet and Consent Form was provided. In this case it was suggested that the person consider their participation, rather than asking them to decide there and then. This provided the person with a period of time to consider involvement, without the pressure of any expectation to make an immediate decision.

3.3.6.1 Inclusion Criteria

Participants were policy actors who have had a role in, and/or knowledge of the implementation of CTG in an early childhood context from local, state and national government, but also including the service providers responsible for implementing policy on the ground. Some community members also participated as they had experience in early childhood CTG strategy consultation processes and advisory roles in early childhood service provision.

3.3.6.2 Exclusion Criteria

The study did not seek to recruit Aboriginal users of services. In addition, not all services working in early childhood were included. Some services fell outside of the CTG remit. For example, child protection is not a target within the CTG strategy although is it an equity issue in Australia (Secretariat of National Aboriginal and Islander Child Care, 2015). Child protection occurs wholly under State policies and therefore was not recognised as part of the CTG strategy under either iteration. Therefore, due to this policy context, and feasibility of the study, organisations exclusively working in child protection were excluded from this study. Although child protection agencies were not included in the study, the intersections between policy activities and child protection were considered during analysis, as the issue emerged from the interviews that were conducted. Mainstream kindergarten and children's centres were not automatically included in the recruitment strategy unless they were known to have a targeted strategy for working with Aboriginal and Torres Strait Islander children and families. Some mainstream service providers were identified through publicly available data on the numbers of Aboriginal children enrolled, or they were recommended by local community members. Further detail cannot be provided in order to protect participant anonymity.

3.3.6.3 Informed Consent

Informed consent was obtained from each participant. The procedures for obtaining free and informed consent are based on providing full disclosure of the nature and purpose of the research, what participation would involve, and measures taken to ensure confidentiality; by using the Introductory Letter, Information Sheet and Consent Form as outlined above. Participants were informed that they are free to make their own personal choice about whether or not to participate. Some participants sought permission or support from their employer regarding their participation in the research. Information about individual decisions, one way or the other, remained confidential, and were not be provided by to any other party within their organisation.

3.3.6.4 Confidentiality

All information provided was treated in strict confidence, and every effort made to protect anonymity of participants throughout. However, anonymity of participants could not be wholly guaranteed, given that a participant might be identifiable by association with information presented in publications arising from the research. There is a risk to a participant's standing or reputation if he or she is associated with comments directly quoted in a research publication, where those comments are perceived by another individual or organisation to be unduly negative or critical, or factually wrong. Through de-identifying transcripts and editing project publications, participant comments that the research team believed might be perceived negatively do not contain information likely to indicate the participant's identity (e.g. by deleting references to specific names, places or events).

Participants had the opportunity to review and amend a verbatim transcript of their interview, prior to any use of the data in project publications, thus also allowing them to remove or quarantine particular comments which they felt might be compromising to their reputation, if they were identified with them. Following transcription, participants were offered the opportunity to receive an electronic (MS Word) copy of the transcript, via email. They were asked to indicate any changes required on this document, and to return it to the research team; or indicate that no changes are required. Only one participant requested a minor change to their transcript which was incorporated in the final version of their transcript, and the previous version destroyed.

Audio recordings and transcriptions of interviews were named in a de-identified form, and stored in a secure location on a Flinders University server. Data will be stored for 7 years and will be deleted from Flinders University servers after that period.

3.3.7 Analysis of findings

Interview transcripts were analysed thematically to search for emergent, repeated patterns of meaning as well as differences (Liamputtong, 2013). The analysis was inductive whereby themes emerged from the data, but the analysis was also deductive to explore ideas of social determinants of Indigenous health, self-determination and decolonisation (Braun & Clarke, 2006). This allowed themes to be explored in relation to the research objectives but also allowed new themes to emerge and be compared to findings from the policy analysis regarding problem representation and Indigenous rights. In addition, the final two questions in Bacchi's approach to analysing problem representation influenced interview data analysis to explore what effects were produced by problems and how or where representations of the 'problem' were produced, disseminated and defended?

3.3.7.1 Coding framework

A coding framework was developed for the Shepparton case study. This provided a foundation for the Southern Adelaide case study however the case studies are so different regarding the implementation of the CTG strategy that an alternate coding framework emerged through analysis of the second of the case study. The complexity of the data in both studies was reflected in an overlap of coding for key concepts. Deep listening during and after interviews, and in preparation for workshops resulted in revisions of coding frameworks as additional meaning and interpretation of ideas was revealed. The coding frameworks therefore served as a guide for initial coding of data but interpretation required a more flexible approach where ideas could be woven together. In some cases, I spread quotes and observations out across the floor and slowly grouped key concepts together by hand. This slower and more tactile process allowed me to reflect on participants' anger, frustration and disappointment with policy implementation as well as the resistance to power imbalances and ongoing colonisation. This is discussed in more detail in my reflection in Chapter 9.

3.3.7.2 Data Analysis Workshops

During data analysis, workshops with research participants in each case study were facilitated to report on research progress and engaged in shared interpretation of the findings to date. This allowed me to discuss emerging findings with Aboriginal participants to explore how I had interpreted data and whether this was consistent with Indigenous ways of knowing. In Shepparton, two workshops were facilitated in April 2018, one with two staff from Rumbalara and another with one external research participants. In Southern Adelaide, one workshop was facilitated in June 2018 for five participants (because there was no formal research partner in the Southern Adelaide case study). All participants signed a consent form at the start of the workshop and agreed to protect anonymity and confidentiality.

All of the workshops during data analysis focused on the following themes:

- A complex and changing policy environment
- A regional approach – or 'place-based' policy
- Aboriginal self-determination in the region
- Social determinants of Indigenous health
- Child health and child rights
- Key messages to government

A member of the research team (either myself or one of my PhD supervisors) took detailed notes at each workshop. In both Shepparton and in Southern Adelaide we met as a team to discuss any new insights and reflect on the contributions of all participants. Detailed minutes from these meetings informed the thematic analysis.

3.3.7.3 'Bringing it all together' workshop

Upon the completion of the data analysis, I facilitated a workshop in July 2019 where all participants were invited so that I could share the results of the policy analysis and case studies. It was important to re-emphasise that this research was not comparing the effort or outcomes of service providers working towards closing the gap in health equity, rather our focus remained on Indigenous rights, social determinants of Indigenous health and decolonisation in policy implementation. All participants were invited to attend. Unfortunately, Rumbalara were unable release staff to attend the workshop but they continued to offer their support for the project from afar. Three participants from Southern Adelaide attend the 'Bringing it all together' workshop. In January 2020, I met individually with another member of Joining Hands and Minds to review the research findings presented at the 'Brining it all together workshop' and discuss relevance to their work and policy implementation processes.

The 'Bringing it all together' workshop focused on the following themes:

- Experiences of consultation
- Understanding self-determination
- Impact of policy implementation on the workforce
- Role of key stakeholders in policy implementation

Participants discussed each theme in detail and supported the findings of the research.

3.4 Ethical Considerations

This research project received ethical approval from three separate ethics committees. The overall CRE-HE project was approved by the Flinders University Social and Behavioural Research Ethics Committee: project number 6786. Following this, the project was approved by the Aboriginal Health Research Ethics Committee (a sub-committee of the Aboriginal Health Council of South Australia Inc): project number 04-16-697, and by the Ethics Committee from Goulburn Valley Health: project number GV39/16.

3.4.1 Embedding Indigenous Knowledge

Embedding Indigenous knowledge throughout this research project in planning, engagement, data collection, data analysis and dissemination was challenging. As a non-Indigenous researcher, self-reflection was essential. Hart (2010) argued that embedding Indigenous knowledge in research requires reflection on axiology: the values or morals that display the respect, reciprocity, and self-awareness that is important in Indigenous knowledge.

Hart (2010) identified values and associated actions to support embedding Indigenous knowledge in research. These actions guided the monitoring process and outcomes of this research at the interface of knowledges. Particular attention was given to the acts of reciprocity in both case studies through community engagement. Table 5 shows these actions, the plan for embedding them within the project, and examples on how this was enacted in the case studies and analysis. More detailed reflection on this process in included in Chapter 9.

Table 5: Embedding Indigenous knowledge

Table 5: Embedding Indigenous knowledge			
Value	Description of Actions (Hart, 2010, pp. 9-10)	Actions applied to the research project	Examples from the research project
Indigenous control over research	Indigenous people developing, approving and implementing the research.	Engagement with key stakeholders in planning, data collection, analysis and dissemination.	Supervision by an Aboriginal academic and the partnership with Rumbalara was essential to the integrity of this research
A respect for individuals and community	Researchers seeking and holding knowledge and being considerate of community and the diverse and unique nature that each individual brings to community.		Community engagement was tailored to the context of each case study. E.g. Netball in Shepparton, and supporting Joining Hands and Minds in Southern Adelaide
Reciprocity and responsibility	Demonstrated in ways a researcher would relate and act within a community, such as sharing and presenting ideas with the intent of supporting a community.	Relationship of reciprocity with key stakeholders and community.	In Shepparton I visited the netball club and facilitated training for multiple teams. In Southern Adelaide I served the community at local events.
Respect and safety	Evident when the research participants feel safe and are safe. This includes addressing confidentiality in a manner desired by the research participants.	Confidentiality and consent ensured.	Confidentiality and consent were ensured through anonymity of participants in both case studies.

Value	Description of Actions (Hart, 2010, pp. 9-10)	Planned application to project	Examples from the research project
Non-Intrusive observation	The researcher would be quietly aware and watching without interfering with the individual and community processes.	No observation of service use or programs was recorded within this study. Field notes referred to observations and reflection on interviews and community engagement from the researcher perspective.	No early childhood services were directly observed as part of the research. It was clearly explained to all participants that comparative case study was not to identify better outcome or effort, rather to understand the process and barriers in policy implementation. Field notes, observation and reflections were from the researcher's perspective.
Deep listening and hearing with more than the ears	The researcher would carefully listen and pay attention to how his/her heart and sense of being is emotionally and spiritually moved.	Open and respectful communication throughout the project and during interviews with participants. Reflection on the context by learning from what was unsaid. Attention paid to both participant and researcher emotive and instinctive responses (e.g. anger, frustration, fear) to observations and data collected throughout the project.	In Shepparton, the historical walk along the river allowed me to be immersed, even if just for a short time on country. In Southern Adelaide a visit to the beach to listen and learn from an Elder offered a similar insight into the importance of acknowledging traditional custodians of the land and history.
Reflective non-judgement	The researcher would consider what is being seen and heard without immediately placement a sense of right or wrong on what is shared and where one would consider what is said within the context presented by the speaker.		In interviews, I learned to allow time for participants to reflect on the challenges of policy implementation, especially when this evoked feelings of sadness or anger. This influenced analysis as I could not ignore the pain of discrimination and disappointment.
To honour what is shared	Translated to fulfilling the responsibility to act with fidelity to the relationships between the participants and the researcher and to what has been heard, observed and learned.	Shared analysis of research findings and commitment to disseminate findings.	Workshops with participants in both case studies allowed me to review the progress and the outcomes of the research and explore any different understands of key concepts. This enhanced my understanding of resistance and resilience. In response to community request, a report on research findings was disseminated among participants and key stakeholders.
Self-awareness	The researcher would listen and observe their self, particularly in relation to others during the research process	Reflection through supervision and peer mentoring.	Peer mentoring challenged me, encouraged me and inspired me throughout this project. Detailed field notes have supported researcher reflexivity.
Subjectivity	The researcher acknowledges that they bring their subjective self to the research process and openly and honestly discuss this subjectivity.		

3.4.2 Peer mentoring

The informal conversations and relationships developed throughout the project supported researcher reflexivity. An important element of this process was the consideration of ‘whiteness’ (Anderson, 2002) and the challenges I faced with research at the interface of knowledge (Durie, 2005). In addition to the mentoring through PhD supervision, and the partnership with Rumbalara, I debriefed what I was learning and the challenges I was facing as a non-Indigenous researcher with an Aboriginal friend who I have worked closely with on health and education projects in the past. Although informal, and mostly unstructured, this friendship became a source of mentorship for me. When I was concerned about how to best engage community and show respect to Elders, they offered support and advice. When I was worried about my own subconscious bias and racism, they encouraged me not to be too hard on myself and look beyond individual experiences to systemic and institutional racism. When I wrestled with the ongoing nature of colonisation, they inspired me to continue to serve as an ally to the Aboriginal communities I am connected to. My reflection on this is included in Chapter 9.

3.4.3 Reflexivity

Muller (2014) explained that decolonisation “is not a simple process; it requires honest personal introspection and commitment to change” (p.54). For non-Indigenous researchers, the challenge presented by Muller (2014) is to explore and debunk myths and assumptions of colonisation. Reflective practice by the researcher and support from the research team was required to review the commitment to embedding indigenous knowledge, promote a decolonising approach, and to identify these same issues within policy. Therefore, in addition to Hart’s actions for embedding Indigenous knowledge in the research project, I also reflected on my role as a non-Indigenous researcher. I was guided by the work of Wilson (2014) and the questions she recommends to unpack researcher reflexivity at 4 distinct phases: identifying the challenges, learning, reaching new levels of understanding, and subsequent changes in practice. My reflection is discussed in detail in Chapter 9.

3.5 Quality of the research

According to Guba (1981) trustworthiness in qualitative research includes credibility, transferability, dependability, and confirmability. I demonstrate the quality of my research and discuss the limitations, by aligning examples from the methodology to each of these criteria.

3.5.1 Credibility

Guba (1981) explained that credible research includes peer debriefing, member checks and triangulation. In this research, I sought peer mentoring from a trusted Aboriginal colleague. My three PhD supervisors met together with me fortnightly while I studied full time (February 2016 – April 2018) and monthly while I studied part time until the completion of my project (May 2018 – September 2020). This regular supervision included reflection on all aspects of the project. If the Aboriginal member of my supervisory team was not available for supervision, I met one-on-one with them outside of those times to review my learning, reflections and progress. These private debrief sessions challenged my thinking on whiteness, power and ongoing colonisation in policy and in research, and enhanced my understanding of these concepts.

Member checking relates to testing the reliability of the data with the participants who helped to generate it (Guba, 1981). As noted, all participants were sent copies of their interview transcripts and only one person requested a revision to the data which was immediately incorporated. Initial coding and interpretation of the data was discussed in PhD supervision. In addition, the workshops during data analysis and at the end of the project supported reliability of the data as participants were invited to discuss key themes as they emerged, prioritising Indigenous knowledge perspectives consistent with research at the interface of knowledge (Durie, 2005). The variety of methods to collect and analyse data was an active process of triangulation where findings and interpretations were cross checked and supported by research participants.

3.5.2 Transferability

As outlined in the literature, colonised Indigenous peoples globally have experiences of marginalisation and discrimination in policy and implementation similar to those experienced by Aboriginal and Torres Strait Islander people (Jackson Pulver et al., 2010). Therefore, findings from my analysis of national policies and two case studies, while specific to their respective contexts, also have broader implications regarding Indigenous rights, social determinants of Indigenous health, and self-determination. Following analysis of the policy documents, two case studies were included in this research to examine the implementation of the CTG strategy in early childhood. Although the context of policy implementation was different, particularly with regard to the role of a local Aboriginal Community Controlled Health Organisation, there were common experiences and themes relating to power and Indigenous rights. According to

(Yin, 2009), a quality case study should be significant, complete, consider alternative perspectives, present relevant evidence, and be rigorous. The case studies were deemed significant as they provided different perspectives on implementation. The depth and breadth of participant data in each case study resulted in the identification of common themes to the point where no new themes emerged. A majority of the participants in both case studies identified as Aboriginal and Torres Strait Islander but I also included non-Indigenous perspectives aligning with the position of this research at the interface of knowledge. Given the ongoing commitment to the CTG strategy by the Australian government, this research is relevant to understanding past policy implementation and to considerations of future policy. The rigour of the study is reflected in the credibility of the analysis and the findings as they are supported by participants in both case studies.

3.5.3 Dependability

Guba (1981) explained that qualitative research is dependable when methods of analysis overlap. An important overlap in this research was the combination of analysis of policy as written and then as implemented in the two case studies. Field notes, observations and reflections also influenced the integration of the findings. This dependability upon multiple sources, coding frameworks, and interpretations, is consistent with research at the interface of knowledge where Indigenous knowledge is respected and valued. In order to ensure that the process of analysis and the findings were dependable, feedback from participants was sought throughout the process.

3.5.4 Confirmability

Guba (1981) argued that credible research reflects neutrality of data and accounts for researcher influence throughout the process. Therefore, to support confirmability, participant sampling was purposive so that no single perspective would dominate and that different knowledges would be valued and respected. The embedding of Indigenous knowledge and privileging of Indigenous voices in the project sought to counteract the power imbalance in policy as result of colonisation. The accuracy and balanced understanding of the case study findings were confirmed by participants during workshops. However, the low numbers of participants in workshops is a notable limitation for confirmability.

3.6 Chapter summary

In this Chapter I have described the philosophical foundations for this research, including the position of this research at the interface of knowledge. Details have been provided about how I have analysed policy and conducted two case studies, including the importance of community engagement, deep listening, and reflexivity. The next chapter will present the findings of the policy analysis.

CHAPTER 4: POLICY ANALYSIS

The policy analysis presented in this Chapter explores the concept of power and the ongoing nature of colonisation in the way that Indigenous rights and social determinants of Indigenous health are explicitly recognised, implied or ignored in policy. As outlined in the methodology Chapter (Chapter 3), problem representations can be analysed according to how ideas in policy reflect values, beliefs and assumptions, and the way that policy problems and solutions are defined, represented and framed. Similarly, Carstensen and Schmidt (2016) argued that ideas in policy reveal the influence of power through actions of control, structure, and the role of institutions. In this Chapter, the analysis of policy documents addresses the first research question:

> To what extent are Indigenous rights prioritised and acted on within the 'Closing the Gap' strategy in early childhood?

In the following sections I firstly define Indigenous rights with reference to the Declaration on the Rights for Indigenous Peoples (United Nations, 2007). Then I outline the policy context and introduce the 12 policy documents on early childhood from the CTG strategy 2008-2018 which are analysed within this Chapter. I present the findings under three orientations towards policy: Indigenous rights are named and recognised, Indigenous rights are implied; and Indigenous rights are undermined or ignored within the CTG policy documents on early childhood. Finally, examples of deficit problem representation consistent with the literature (Carter et al., 2009; Klein, 2015; Sullivan, 2011) are identified to highlight silences and assumptions within policy documents.

4.1 Indigenous Rights

The Declaration on the Rights of Indigenous Peoples affirmed the dignity and rights for Indigenous people individually and collectively (United Nations, 2007). Macdonald and Wood (2016) understand Indigenous rights as more than a human right to a universal personhood, because Indigenous rights also acknowledge the right to an Indigenous identity based on political and cultural specificity of a particular collective. The declaration promotes the enaction of Indigenous rights through promoting freedom from discrimination, self-determination and the maintenance and strengthening of Indigenous institutions. Indigenous rights are sovereign rights unique to First Nations people who are the traditional owners of land. These rights seek to protect traditional customs, knowledge and language (Healey, 2014). Therefore, Indigenous rights are recognised as an extension of universal human rights and they seek to address the inequities arising from colonial forces of dispossession and discrimination. The argument that Indigenous rights are separate from universal human rights is contested, Macdonald and Wood (2016) argued that where Indigenous rights are recognised, they can only be acted upon to an extent that they do not contradict universal human rights, state sovereignty, or Western notions of individual rights. Lightfoot (2012) described a practice of selective endorsement of Indigenous rights whereby governments under-commit to international norms such as the Declaration on the Rights of Indigenous Peoples, but at the same time, they preserve an identity as a human rights supporting state. Excluding Indigenous rights from policy is more likely to support existing colonial power structures and resist decolonisation. Macdonald and Wood (2016) argued that the Declaration on Rights for Indigenous Peoples can actually be used to protect the colonial positioning of Indigenous people's as the 'included-excluded', meaning that Indigenous rights can be named and even celebrated, but implementation of policy still excludes the rights of Indigenous people. The contested recognition of Indigenous rights is relevant in the Australian context where there is no treaty between Aboriginal and Torres Strait Islander people and the Commonwealth. While the Declaration on Rights for Indigenous People has not been adopted into Australian law, it is still possible for rights to be recognised in public policy, explicitly or implicitly, and in partial ways (Fisher et al., 2018).

Despite the contested nature of Indigenous rights, they remain important for health and well-being consistent with an Aboriginal definition of health (National Aboriginal Community Controlled Health Organisation, 2006). The objective in answering the research question is to analyse CTG policy documents on early childhood to assess the extent to which they recognise Indigenous rights and social determinants of Indigenous health, and incorporate beliefs, goals and strategies consistent or inconsistent with principles of decolonisation.

4.2 Policy Context

The CTG policy documents I analyse in this thesis cover the period from 2008-2018. As outlined in the methodology Chapter, in a decade of CTG strategy, there have been two iterations of policy which relate to changes in government. Table 6 provides an overview of the policies from both iterations of the CTG strategy relating to early childhood, outlining the purpose of the policy with reference to a document aim, vision or objectives. The documents are numbered and referred to by name and number throughout the Chapter.

Table 6: Closing the Gap policy documents including aims, vision or objectives

Table 6: CTG policy documents including aims, vision or objectives	
CTG 2008-2013	
#	Policy Title
1.	National Indigenous Reform Agreement (Closing the Gap) 2011
	COAG agreed to the following targets: a) Closing the life expectancy gap within a generation; b) Halving the gap in mortality rates for Indigenous children under five within decade; c) Ensuring all Indigenous four-year olds in remote communities have access to early childhood education within five years; d) Halving the gap for Indigenous students in reading, writing and numeracy within a decade; e) Halving the gap for Indigenous people aged 20-24 in Year 12 attainment or equivalent attainment rates by 2020; and f) Halving the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade. (p.8).
2.	National Partnership Agreement on Indigenous Early Childhood Development (2009 -14)
	"To reduce the gap in developmental outcomes between Indigenous and non-Indigenous children… a) Halve the gap in mortality rates for Indigenous children under five within a decade b) Halve the gap for Indigenous students in reading, writing and numeracy within a decade; and To ensure all Indigenous four-year olds in remote communities have access to early childhood education within five years" (p.2).
3.	National Partnership Agreement on Early Childhood Education
	"To improve the supply and integration of early childhood services, including child care and early learning and development, through the delivery of universal access to quality early childhood education in the year before full time schooling" (p.3).

#	Policy Title
4.	National Aboriginal and Torres Strait Islander Health Plan 2013-23 (NATSIHP)
	Vision: “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” (p.8)
5.	National Education Agreement
	Vision: “The Commonwealth, State and Territory Governments of Australia recognise that ensuring all young people have the best possible start in life is vital to the well-being of families, communities and the nation as a whole. High-quality schooling supported by strong community engagement is central to Australia’s future prosperity and social cohesion” (p.3).
6.	Investing in the Early Years – A National Early Childhood Development strategy
	Vision: “by 2020 all children have the best start in life to create a better future for themselves and for the nation” (p.4).
CTG 2013-2016	
7.	Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 – (IP-NATSIHP)
	“To realise health equality by 2031… This 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 peoples through the health system. It also focuses on supporting local and regional responses to identified needs. The Implementation Plan will drive the focus for further collaboration across government and the Australian health system to improve health outcomes of current and future generations of Aboriginal and Torres Strait Islander peoples” (p.V).
8.	National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families
	“The Framework describes: • A vision for health services for Aboriginal and Torres Strait Islander families that focuses on children and families accessing high-quality evidenced based and culturally-safe child and family health services to support optimal health, development and wellbeing; and Nine principles relating to: access; equity; Aboriginal and Torres Strait Islander leadership and partnership in the planning and delivery of child and family health services; collaboration between all levels of government, between health service providers and other sectors; an evidence and strengths-based approach to the funding, design and delivery of child and family services; cultural respect; workforce development; and accountability” (p.1).

#	Policy Title
9.	National Aboriginal and Torres Strait Islander Education Strategy (signed 2015)
	Vision: "All Aboriginal and Torres Strait Islander children and young people achieve their full learning potential, are empowered to shape their own futures, and are supported to embrace their culture and identity as Australia's First Nations peoples" (p.2).
10.	National Partnership Agreement on Universal Access to Early Childhood Education 2016 and 2017
	"The policy builds on the aims of the previous two agreements with a commitment "to maintaining universal access to quality early childhood programmes for all children in the year before full-time school for 600 hours per year, delivered by a qualified early childhood teacher, who met National Quality Framework (NQF) requirements, with a focus on participation by vulnerable and disadvantaged children" (p.2).
11.	National Quality Agenda for Early Childhood Education and Care
	"The Commonwealth, States and Territories are committed to maintaining their focus on the early years to ensure the wellbeing of children throughout their lives, and to deliver the vision of the Early Childhood Development Strategy (ECDS) endorsed by the Council of Australian Governments (COAG) in July 2009 that 'by 2020 all children have the best start in life to create a better future for themselves, and for the nation" (p.2).
12.	Indigenous Advancement Strategy – Grant Guidelines (IAS)
	"the Australian government has set three clear priorities to make sure efforts are effectively targeted. • The positive impact that education has on the future success of individuals, families and communities is clear. Children who go to school have better life outcomes. • Employment, economic development and social participation improves the lives of families and communities. The right conditions and incentives need to be in place for Indigenous Australians to participate in the economy and broader society. Growing up in a healthy and safe home and community is essential for families to thrive and reach their full potential. In particular, the violence that too many women and children face must be addressed" (p.6).

4.3 Findings from the Policy Analysis

The 12 policy documents were coded using NVivo 11 software. The coding framework was designed to identify themes specifically related to the research question. Additional themes emerged from the analysis of the policies. Attention was paid to differences in aims and goals of policies and whether Indigenous rights and social determinants of Indigenous health were explicitly embedded into proposed strategies, whether they were implied, or ignored. Underlying assumptions and problematisations within policy were coded under a theme of ‘ideas and values’. These ideas and values related to themes within the literature on power, deficit problem representation and the provision of services through a mainstream model (Black & McBean, 2016; Brown, 2009; Carter et al., 2009; Cooper, 2011; Goodman et al., 2017; Klein, 2015; D. Smith, 2007; Sullivan, 2011a; Wilmot, 2018). Analysis was informed by the literature which highlighted the dominance of positivist approaches to health care that exclude Indigenous health perspectives (Cooper, 2011; Lavoie, 2014; Ronald & Koea, 2013; Sullivan, 2011; Unal, 2018). Policies were also coded for the explicit inclusion of self-determination, as an Indigenous right. I found that when policies document principles of self-determination, they also included commitments to Indigenous leadership. In some policy documents, self-determination was named and recognised but in other documents it was implied.

Three orientations of policy emerged from the analysis of policy documents to show:

- Indigenous rights are named and recognised
- Indigenous rights are implied
- Indigenous rights are undermined or ignored within the CTG policy documents.

Indigenous rights were considered to be named and recognised when policies included: Indigenous leadership; self-determination; social determinants of Indigenous health; and documented culture as a strength. Indigenous rights were seen as implied when policies: recognised the importance of an Indigenous voice; identified social determinants of health within conditions of daily living as problems to be addressed or as a means of solving problems; or when policies included Indigenous-specific policy or targeted actions, often connected to social determinants of Indigenous health. Then, Indigenous rights were seen as undermined or ignored when policy strategies: prioritised mainstream service provision; promoted universal access to services; where assumptions reflected colonial power structures; and policies strategies focused on deficit problem representation.

Tables 7, 8 and 9 summarise the results to show how each policy document was mapped against the subthemes.

Table 7: Mapping policies where Indigenous rights are named and recognised

Table 7: Mapping policies where Indigenous rights are named and recognised					
CTG 2008-2013					
#	Policy	Sub themes			
		Indigenous leadership	Self-determination	Social determinants of Indigenous health	Culture as strength
1.	National Indigenous Reform Agreement (Closing the Gap) 2011	✓	✓		✓
2.	National Partnership Agreement on Indigenous Early Childhood Development (2009 - 14)				
3.	National Partnership Agreement on Early Childhood Education				
4.	National Aboriginal and Torres Strait Islander Health Plan 2013-23 (NATSIHP)	✓	✓	✓	✓
5.	National Education Agreement				
6.	Investing in the Early Years – A National Early Childhood Development strategy			✓	
CTG 2013-2016					
7.	Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 – (IP-NATSIHP)	✓	✓	✓	✓
8.	National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families	✓	✓	✓	✓
9.	National Aboriginal and Torres Strait Islander Education Strategy (signed 2015)	✓			✓
10.	National Partnership Agreement on Universal Access to Early Childhood Education 2016 and 2017				
11.	National Quality Agenda for Early Childhood Education and Care				
12.	Indigenous Advancement Strategy – Grant Guidelines (IAS)			✓	✓

Table 8: Mapping policies where Indigenous rights are implied

Table 8: Mapping policies where Indigenous rights are implied				
CTG 2008-2013				
#	Policy	Sub themes		
		Indigenous voice	Social determinants of health	Indigenous specific policy actions
1.	National Indigenous Reform Agreement (Closing the Gap) 2011	✓	✓	
2.	National Partnership Agreement on Indigenous Early Childhood Development (2009 -14)		✓	
3.	National Partnership Agreement on Early Childhood Education	✓	✓	
4.	National Aboriginal and Torres Strait Islander Health Plan 2013-23 (NATSIHP)	✓	✓	
5.	National Education Agreement	✓	✓	
6.	Investing in the Early Years – A National Early Childhood Development strategy		✓	✓
CTG 2013-2016				
7.	Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 – (IP-NATSIHP)	✓	✓	
8.	National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families	✓	✓	✓
9.	National Aboriginal and Torres Strait Islander Education Strategy (signed 2015)	✓	✓	
10.	National Partnership Agreement on Universal Access to Early Childhood Education 2016 and 2017		✓	
11.	National Quality Agenda for Early Childhood Education and Care		✓	
12.	Indigenous Advancement Strategy – Grant Guidelines (IAS)		✓	✓

Table 9: Mapping policies where Indigenous rights are undermined or ignored

Table 9: Mapping policies where Indigenous rights are undermined or ignored					
CTG 2008-2013					
#	Policy	Sub themes			
		Universal access to services	Mainstream service provision	Colonial power imbalance maintained	Deficit problem representation
1.	National Indigenous Reform Agreement (Closing the Gap) 2011	✓	✓	✓	
2.	National Partnership Agreement on Indigenous Early Childhood Development (2009 -14)	✓	✓		
3.	National Partnership Agreement on Early Childhood Education	✓		✓	
4.	National Aboriginal and Torres Strait Islander Health Plan 2013-23 (NATSIHP)				
5.	National Education Agreement	✓			
6.	Investing in the Early Years – A National Early Childhood Development strategy	✓	✓	✓	✓
CTG 2013-2016					
7.	Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 – (IP-NATSIHP)				
8.	National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families	✓		✓	
9.	National Aboriginal and Torres Strait Islander Education Strategy (signed 2015)	✓			
10.	National Partnership Agreement on Universal Access to Early Childhood Education 2016 and 2017	✓			
11.	National Quality Agenda for Early Childhood Education and Care	✓			
12.	Indigenous Advancement Strategy – Grant Guidelines (IAS)		✓	✓	✓

4.4 Recognising Indigenous Rights across a Spectrum

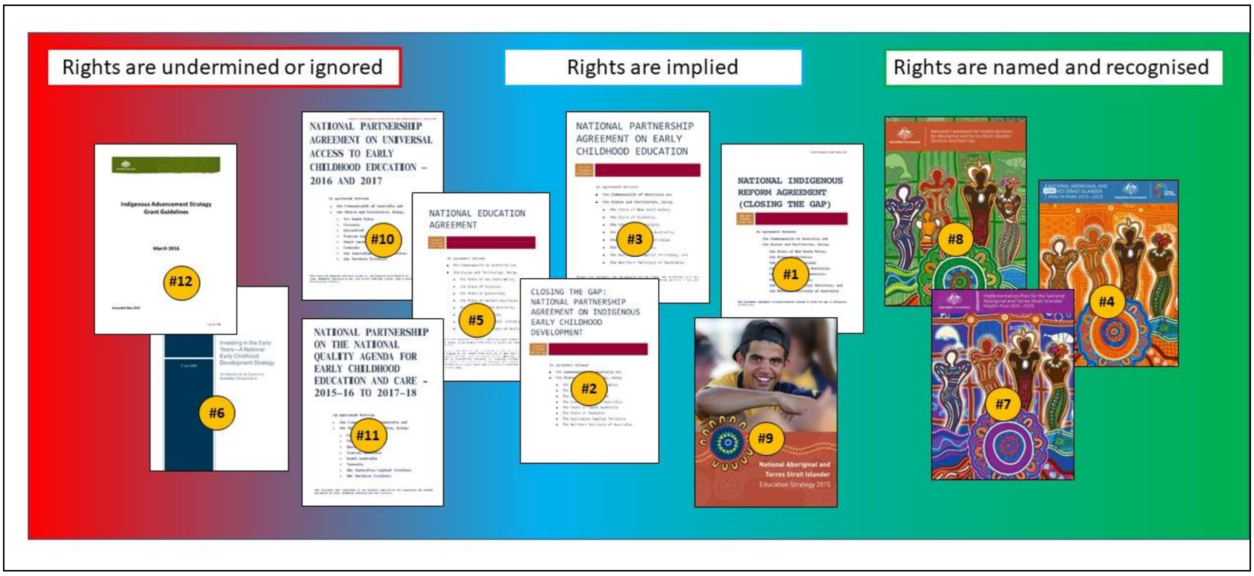
All of the policy documents include a reference to social determinants of health, often with strategies targeting conditions of daily living. In some policies, relevant social factors were referred to as problems (e.g. poverty or disadvantage, and the prevalence of alcohol misuse or violence), but in other policies as solutions (e.g. the provision of education, housing and employment). This different framing of social determinants of health was described in the literature as a contrast between colonising, deficit based approaches to policy, verses an approach where underlying ideas and values in policy reflect culture as a strength and essential part of policy implementation (Carter et al., 2009; Klein, 2015; Sullivan, 2011). Therefore, in order to understand the extent to which Indigenous rights have been recognised across all analysed documents, the breadth of the themes was analysed and is summarised in Table 10.

Table 10: To what extent are Indigenous rights prioritised within the CTG strategy on early childhood?

<table>
<tr><th colspan="13">Table 10: To what extent are Indigenous rights prioritised within the CTG strategy on early childhood?</th></tr>
<tr><td colspan="13">CTG 2008-2013</td></tr>
<tr><td>#</td><td>Policy</td><td colspan="4">Named and recognised</td><td colspan="3">Implied</td><td colspan="4">Undermined or Ignored</td></tr>
<tr><td>1.</td><td>National Indigenous Reform Agreement (Closing the Gap) 2011</td><td>✓</td><td>✓</td><td></td><td>✓</td><td>✓</td><td>✓</td><td></td><td>✓</td><td>✓</td><td>✓</td><td></td></tr>
<tr><td>2.</td><td>National Partnership Agreement on Indigenous Early Childhood Development (2009 -14)</td><td></td><td></td><td></td><td></td><td></td><td>✓</td><td></td><td>✓</td><td>✓</td><td></td><td></td></tr>
<tr><td>3.</td><td>National Partnership Agreement on Early Childhood Education</td><td></td><td></td><td></td><td></td><td>✓</td><td>✓</td><td></td><td>✓</td><td></td><td>✓</td><td></td></tr>
<tr><td>4.</td><td>National Aboriginal and Torres Strait Islander Health Plan 2013-23 (NATSIHP)</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>5.</td><td>National Education Agreement</td><td></td><td></td><td></td><td></td><td>✓</td><td>✓</td><td></td><td>✓</td><td></td><td></td><td></td></tr>
<tr><td>6.</td><td>Investing in the Early Years – A National Early Childhood Development strategy</td><td></td><td></td><td>✓</td><td></td><td></td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td></tr>
<tr><td colspan="13">CTG 2013-2016</td></tr>
<tr><td>7.</td><td>Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 – (IP-NATSIHP)</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>8.</td><td>National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td></td><td>✓</td><td></td></tr>
<tr><td>9.</td><td>National Aboriginal and Torres Strait Islander Education Strategy (signed 2015)</td><td>✓</td><td></td><td></td><td>✓</td><td>✓</td><td>✓</td><td></td><td>✓</td><td></td><td></td><td></td></tr>
<tr><td>10.</td><td>National Partnership Agreement on Universal Access to Early Childhood Education 2016 and 2017</td><td></td><td></td><td></td><td></td><td></td><td>✓</td><td></td><td>✓</td><td></td><td></td><td></td></tr>
<tr><td>11.</td><td>National Quality Agenda for Early Childhood Education and Care</td><td></td><td></td><td></td><td></td><td></td><td>✓</td><td></td><td>✓</td><td></td><td></td><td></td></tr>
<tr><td>12.</td><td>Indigenous Advancement Strategy – Grant Guidelines (IAS)</td><td></td><td></td><td>✓</td><td>✓</td><td></td><td>✓</td><td>✓</td><td></td><td>✓</td><td>✓</td><td>✓</td></tr>
</table>

Table 10 shows that some policies (such as the National Indigenous Reform Agreement, policy #1) can name and recognise, imply, and undermine and ignore Indigenous rights all within one document. The results are more like a spectrum and none of the policy documents fully recognise Indigenous rights and none of them fully undermine Indigenous rights. In analysing the documents, the underlying ideas and values that are embedded with the policy vision, goals and objectives influenced the extent to which Indigenous rights are recognised. I found that the policy documents fall somewhere across a spectrum as shown in Figure 5.

Figure 5: Recognising Indigenous rights across a spectrum (Image by Emma George)



Analysing policy vision, goals and objectives showed this spectrum also reflected different approaches to health and well-being. The policies in which Indigenous rights are named and recognised are founded upon the importance of culture as a determinant of health. The National Aboriginal and Torres Strait Islander Health Plan (NATSIHP, policy #4), the corresponding Implementation Plan (IP-NATSIHP, policy #7) and the National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families (policy #8), highlight culture as essential for well-being of people and communities. The commitment to an Aboriginal understanding of health (National Aboriginal Community Controlled Health Organisation (NACCHO), 2006) is then reflected within each policy. For example, NATSIHP (policy #4) documents a vision that goes beyond targets for life expectancy for an "Australian health system 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" (p.8). The IP-NATSIHP (policy #7) directs policy attention to the rights of Aboriginal children when it states: “Strong identity and pride in being an Aboriginal and Torres Strait Islander child is central to facilitating strong, resilient children who are able to negotiate the world. Using cultural knowledge and teaching enables children and their families to draw on their strengths, feel pride and confidence, and ensure holistic health for their children” (p. 21). Then the National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families (policy #8) draws on the foundation within the NATSIHP documents (policy #4, #7) with a vision that “Aboriginal and Torres Strait Islander children and their families access high quality, evidence-based and culturally safe child and family health services to support their optimal health, development and wellbeing” (p.9). The vision and ideas represented in these policy documents acknowledge culture as a vital determinant of health, and represents Indigenous people as valued members of society with pride, resilience, knowledge, and confidence (IP-NATSHIP, policy #7).

Most of the policies focused more on social inclusion than culture and identity. This shift in terminology influences policy goals, objective and outcomes, repositioning culture away from a central focus, to be something that is included within a mainstream context. For example, the Indigenous Early Childhood National Partnership Agreement (policy #2) was developed to “improve outcomes for Indigenous children in their early years and to contribute to COAG Closing the Gap targets for Indigenous Australians” (p.2). This policy is measured by progress towards the targets of reducing gaps in child mortality, literacy and numeracy, and access to early childhood education. This is a very different focus to other policies with a vision for the freedom from racism, and the promotion of culture and identity. The Indigenous Early Childhood National Partnership Agreement includes specific outcomes for establishing children’s centres where services are integrated, parents are active participants, and centres should be built upon community engagement. Similarly, the National Education Agreement (policy # 5) documents a vision for “social inclusion, including responding to Indigenous disadvantage” (p.3), but then policy outputs are measured only by enrolment in school, and not by engagement in school, language and culture at school, or cultural safety in institutions. This indicates that there are silences within the policy documents.

An underlying issue preventing the full recognition of Indigenous rights is the ongoing nature of colonisation (Cooper, 2011). The literature reviewed in Chapter 2 highlighted the contrast between colonising, deficit-based approaches to policies, with decolonising policies built upon the strengths of Indigenous cultures (Carter et al., 2009; Klein, 2015; Sullivan, 2011). As previous stated, even when Indigenous rights and social determinants of Indigenous health are included in policy, implementation in these areas is often inconsistent and not prioritised by governments (Cooper, 2011; Klein, 2015; Robertson et al., 2012; Smith, 2007). Therefore, to understand the extent to which Indigenous rights are prioritised in the CTG strategy, the dominant themes are discussed.

4.4.1 Indigenous rights are undermined or ignored

Indigenous rights were thought to be undermined or ignored when the policy actions focused on mainstream service provision or universal access, rather than self-determination or promotion of Indigenous leadership. Much of the literature, showed that a focus away from Indigenous control, is unlikely to reduce the existing power imbalance between Aboriginal and Torres Strait Islander people and governments, and tends to represent problems and solutions in policy in deficit terms (Brown, 2009; Cooper, 2011; Lavoie & Dwyer, 2016; Shewell, 2016; Smith, 2007). My analysis revealed this focus away from Indigenous control within some of the policy documents. For example, the most recent policy document, the Indigenous Advancement Strategy (IAS, policy # 12) brought significant reform in the administration and delivery of services and programs. The IAS consolidated numerous initiatives with a budget of $4.8 billion over four years from the 2014-2015 financial year. Within the IAS grant guidelines, there is recognition of the need for Indigenous people to be “actively involved in the development and delivery of local solutions” (p.6), but in all examples, there is no specific mention of self-determination. Indigenous leadership is represented in the IAS as lacking because the problem is framed as a lack of skills, resulting in an inability to make decisions. This is shown, for example, when the policy says, “Developing the leadership skills of Indigenous Australians will contribute to strengthening the governance and capabilities of Indigenous people as leaders and organisations. This includes strengthening personal leadership, so that people are better equipped to make sound decisions about their own futures, and about matters that impact on their families” (IAS, p.48). In this example, the lack of Indigenous leadership is framed as a problem of inability of Indigenous people themselves. This problem representation does not reflect the causes of inequality or inequity, the structural power imbalance, or the trauma of colonisation and the ongoing legacy of dispossession. This problem representation with the IAS also fails to acknowledge the leadership already shown by Indigenous people through development of policy such as the NATSIHP (policy # 4), in advocating for Indigenous leadership and the integration of social determinants of Indigenous health into policy (Fisher et al., 2018).

The power of the government over sovereign Indigenous rights is also seen in the process of grant applications through the IAS whereby open grant applications are permitted but the government can also invite applications through a targeted process. Within the grant guidelines there is no discussion of equitable distribution of funds to Aboriginal organisations specifically. Power is further removed from grant recipients and a deficit narrative is maintained through the concept of “earned autonomy” (IAS p 22). If grant recipients meet expectations of implementation and reporting, then they will be “subject to less monitoring and oversight” (p.22). This is despite the recognition within the policy document that “the majority of grant recipients comply with their obligations” (p22). The assumption in this problem representation is that some recipients of funding do not have a right to autonomy, and therefore the default position is to address unsatisfactory performance by excessive paternalistic oversight for all grant recipients. This assumption contrasts with the role of Aboriginal Community Controlled Health Organisations in other policies such as the NATSIHP (policy #4) where they are identified as key stakeholders to improving health and well-being of Indigenous people and communities.

There are other policy documents where Indigenous rights are ignored and a deficit approach is hidden within assumptions and policy structure. ‘Investing in the Early Years’ - A National Early Childhood Development Strategy (policy #6) is built upon principles supporting “social, emotional and cultural dimensions and learning throughout life” (p.4). There are examples within this policy of an equitable approach whereby additional support is available to children in most need in order to reduce social inequalities including “some Indigenous children who, on average have significantly poorer outcomes than non-Indigenous children” (p.4). However, there is an underlying priority in this policy for children to make an important future contribution to society, emphasising an economic value. The policy document states that better support for families can be provided through policies, services and programs “to ensure the best possible outcomes for children and to contribute to Australia’s economic goals by supporting workforce participation now and into the future” (p.6). The ‘Investing in the Early Years’- National Early Childhood Development Strategy presents a clear argument on the importance of early life experiences, but this is placed within a context of having benefit for society resulting in increased productivity and reduced public expenditure. This policy explicitly highlights economic value but is silent on self-determination and social determinants of Indigenous health.

In addition, a key feature of the majority of policy documents in health and education is the push towards integrating Aboriginal and Torres Strait Islander people, children and families into mainstream education and employment. It was expected that the broader policies in education such as the National Partnership Agreement on Early Childhood Education (policy #3) and the National Education Agreement (policy #5) from the first iteration of CTG, along with the National Partnership Agreement on Universal Access to Early Childhood Education 2016-2017 (policy #10) and the National Quality Agenda for Early Childhood Education and Care (policy #11) from the second iteration, would take a wider approach to the provision of services, because these policies were not Indigenous specific although they do state that they will make a contribution to closing the gap targets. For example, the objectives of the National Partnership Agreement on Universal Access to Early Childhood Education 2016-2017 (policy #10, p.3) include:

- *The objective of this Agreement is to facilitate children's early learning and development and transition to school, by maintaining universal access to, and improving participation in, affordable, quality early childhood education programmes for all children.*
- *This objective is to be achieved through universal access to quality early childhood education programmes for all children enrolled in the year before full-time school for 600 hours per year, delivered by a qualified early childhood teacher who meets NQF requirements, and with a focus on participation by Indigenous, vulnerable and disadvantaged children, regardless of the setting in which programmes are delivered.*
- *Children living in remote Indigenous communities remain a focus for universal access.*

Universal access to services promoted within these broader policies is consistent with universal human rights. However, avoiding Indigenous leadership and self-determination through the promotion of mainstream and universally accessible services demonstrates that human rights can be promoted for some people, while Indigenous rights are simultaneously absent or ignored. For example, the National Partnership Agreement on Early Childhood Education (policy #3) recognises that increasing access for Indigenous children to universal early childhood education is a policy priority but there are no Indigenous specific policy strategies proposed to support this. The underlying assumption is that Indigenous children will engage in the mainstream early childhood education system but there is no inclusion within policy strategies relating to flexibility in the type or education, language, or cultural safety of programs provided for children accessing universally available services. The promotion of mainstream or universal services without Indigenous leadership or self-determination highlights how universal human rights can be included in policy without a parallel focus on Indigenous rights.

4.4.2 Indigenous rights are implied

Policies that included an Indigenous voice, policy action on the conditions of daily living, and outlined Indigenous specific programs or outcomes, were more likely to be supportive of Indigenous rights and therefore rights to Indigenous leadership and self-determination were implied. Every policy document in this analysis included the social determinants of health, either by referring to the conditions of daily living as problems or solutions. Seven national policies with an educational focus (National Partnership Agreement on Indigenous Early Childhood #2, National Partnership Agreement on Early Childhood Education #3, National Education Agreement #5, 'Investing in the Early Years' – National Early Childhood Development Strategy #6, National Aboriginal and Torres Strait Islander Education Strategy #9, National Partnership Agreement on Universal Access to Early Childhood Education #10, and the National Quality Agenda for Early Childhood Education and Care #11) from both iterations of the CTG strategy all recognised that education itself is an important determinant of health. For example, the National Partnership Agreement on Early Childhood Education (policy #3), aspires to "support care and education throughout early childhood that equips [children] for life and learning" (p.5). Comparing the position of these policies across the spectrum of how Indigenous rights are recognised, shows that some policies leaned more towards recognising Indigenous rights than others. In particular, the National Aboriginal and Torres Strait Islander Education Strategy (policy #9) stated that "Aboriginal and Torres Strait Islander people are the first Australians with the oldest continuing cultures in human history. Governments across Australia affirm the right of Aboriginal and Torres Strait Islander people to maintain languages and cultures and acknowledge their deep cultural associations with the land and water" (p.i). The vision for this policy is then for Aboriginal and Torres Strait Islander children to shape their own future. This is supported by priorities for partnership between education sectors and local Aboriginal and Torres Strait Islander communities, "characterised by listening and responding, strong accountability and active engagement, collaborative information sharing and informed decision making with local communities and informed decision making" (p.5). The priorities for action within the education system support partnership and Indigenous voice, even though self-determination as an Indigenous right is not specifically named in the policy document. The education system itself is already built upon a mainstream service provision model with universal access. This National Aboriginal and Torres Strait Islander Education Strategy (policy #9) includes Indigenous specific policy action that is embedded within the wider system. This policy calls for cultural recognition where “Aboriginal and Torres Strait Islander people’s histories, values, languages and cultures are acknowledged and respected” (p.3). Including a recognition of Indigenous rights to some extent within the policy shows that this policy implies Indigenous rights, even when they are not always specifically named as rights within the document.

The six other education policies (#2, 3, 5, 6, 10, 11) included in this analysis are positioned closer to Indigenous rights being undermined or ignored on the spectrum of recognising Indigenous rights. The focus on universal access to early childhood services is a prominent feature of these policies. The strongest push towards universal access is embedded with the ‘Investing in the Early Years’ – A National Early Childhood Development Strategy (policy #6) which states the “advantages of universal programs may include greater accessibility, reduced stigma, and a role in assessing and referring those children in need to additional support” (p. 9). This policy does not balance discussion of these advantages with recognition of possible limitations, although it does state that “universal health and early childhood education and care services have difficulty engaging with some children and families. This is particularly so with some Indigenous children and families” (p.11). The challenges presented to accessing universal services seem to contradict the advantages listed on page 9. This policy goes on to list potential barriers and in doing so, shares the blame between systemic failures and representing people needing the services themselves as the problem when it states: “Barriers to accessing services include availability of services, cost, lack of awareness, a chaotic home life, cultural appropriateness, lack of trust, distance from the service and lack of transport” (p.11). The concluding argument for universal services in ’Investing in the Early Years’ – A National Early Childhood Development Strategy is that “universal programs have been shown to be cost-effective” (p.36).

The education policies in this analysis reflect a balance between universal access in a mainstream health and education sector, and Indigenous specific service provision. From the outset of the CTG strategy, and documented within the introduction of the National Indigenous Reform Agreement (policy #1), specific targets in early childhood were established for “ensuring all Indigenous four-year-olds in remote communities have access to early childhood education” (p.8), and this is supported in all other national education policy documents. The inclusion of Indigenous specific targets implies some recognition of Indigenous rights, however broader analysis of the policies showed that there is a lack of specific action embedded within policy to enact self-determination and Indigenous leadership. Thus, strategies on Indigenous rights seem to get lost within the mainstream system. The National Aboriginal and Torres Strait Islander Education Strategy (policy #9) described universally accessible services as a “pathway to targeted and intensive services” (p.18) but this deficit focus does not address the barrier that some Indigenous children and families face in accessing universal services as described in ‘Investing in the Early Years’ - A National Early Childhood Development Strategy (policy #6). The ’Investing in the Early Years’ strategy argues that are no “wrong doors” within a mainstream system as it should be structured in a responsive way so that any point of initial inquiry will provide access to a broader range of appropriate services and programs. “The aim is for children and families to receive the right level of support in the most effective way and in a timely manner, without unnecessary referrals to other services” (p.18). However the literature showed that universal and mainstream services risk not meeting the needs of the community (Lavoie, 2014), and Indigenous people have concerns that mainstream services are tokenistic (Ronald & Koea, 2013), and the positive impact on health and well-being is difficult to measure (Wilmot, 2018). The ‘Investing in the Early Years’ – A National Early Childhood Development Strategy (policy #6) “no wrong doors” analogy assumes that people will be able to find the door and feel safe to open it. This policy lacks the focus on culture in comparison to the National Aboriginal and Torres Strait Islander Education Strategy (policy #9). The model within the ‘Investing in the Early Years’ strategy (policy #6) with universally accessible, targeted and intensive services is consistent with universal human rights, but not always inclusive of Indigenous rights, which are absent from this policy document.

Indigenous voice and associated policy strategies for implementation were observed in policy documents through commitments to partnership and collaboration with Aboriginal and Torres Strait Islander people and communities. The National Partnership Agreement on Indigenous Early Childhood Education (policy #3) stated that consultation and engagement are fundamental to success and the achievement of policy objectives. “Engagement with all key partners and stakeholders, including but not limited to early childhood service providers (including non-government organisations), parent and community groups, Indigenous communities and industry peak bodies, should be ongoing for the duration of this Agreement” (p.11). The importance of Indigenous voice was more clearly outlined within the National

Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families (policy #8). The framework advocates for "meaningful partnership of Aboriginal and Torres Strait Islander people in all decision making including the planning, funding, delivery and review of child and family services" (p.14). Some of the policies that promoted an Indigenous voice did not also include a focus on Indigenous leadership. For example, the Partnership Agreement Indigenous Early Childhood National (policy #2) states that "all governments recognise that substantial benefits can be realised from working in partnership, in engaging with local government and non-government service providers and the community, and in taking a child-focused approach to policy development and service delivery" (p.4). This example demonstrates a commitment to collaboration but this only implies a recognition of Indigenous rights because the policy strategies are silent on Indigenous leadership and self-determination.

4.4.3 Indigenous rights are named and recognised

Policies that clearly documented the role of Indigenous leadership, the right to self-determination, focused on social determinants of Indigenous health, and described culture as a strength, recognised Indigenous rights to a greater extent. Although the broader policy environment in an era of ongoing colonisation prevents full recognition of rights, three policies stood out from other policies because they featured all subthemes associated with naming and recognising Indigenous rights. These three polices are the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP, policy #4), the Implementation Plan for the NATSIHP (IP-NATSIHP, policy #7) and the National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families (policy #8). As a founding document, the NATSIHP (policy #4) importantly acknowledged the ongoing impact of colonisation where it says "Experiences of racism are compounded by the traumatic legacy of colonisation, forced removals and other past government discriminatory policies. The consequences of these events have been profound, creating historical disadvantage that has been passed from one generation to the next" (p.15). This shifts problem representation from a deficit narrative positioning Indigenous people as the problem themselves, to a problem of colonisation and systemic failures that have resulted in inequality and inequity. In support of the NATSIHP, the National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families (policy #8) called for a different approach that recognises "the traumatic legacy and ongoing effects of colonisation, the removal of Aboriginal and Torres Strait Islander children from their families, persisting interpersonal and institutional racism, and the impact these have on the health and wellbeing of Aboriginal and Torres Strait Islander people, and their decision about where and how they access services" (p. 5). This is a very different problem representation than policies which document "a chaotic home life" as a barrier to accessing services.

These policies that name the causes of health inequity and highlight the ongoing impact of colonisation, then highlight the importance of Indigenous leadership and self-determination as a sovereign Indigenous right. The NATSIHP (policy #4) promoted community-controlled health organisations because they provide a unique contribution in delivering holistic, comprehensive and culturally appropriate health care. This policy outlines "Aboriginal and Torres Strait Islander community-controlled health organisations are an important element of the health system and provide a mechanism for Aboriginal and Torres Strait Islander people to actively lead, develop, deliver and be accountable for culturally appropriate health services" (p.23). The Implementation Plan for the NATSIHP (policy #7) adds to this and explains "Community control is a process which allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols or procedures are determined by the community. Aboriginal community control has its origins in Aboriginal people's right to self-determination. This includes the right to be involved in health service delivery and decision making according to… the Aboriginal holistic definition of health" (p.52).

The link between Indigenous rights and health and well-being is clearly presented in the NATSIHP (policy #4) where it states "Individual and community control over their physical environment, dignity and self-esteem, respect for Aboriginal and Torres Strait Islander people's rights and a perception of just and fair treatment is also important to social and emotional well-being" (p.21). In this policy, and subsequent implementation plan (policy #7) and the corresponding National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families (policy #8), culture is represented as a strength and Indigenous rights are central to health and wellbeing. There is no mention in these policies of an economic contribution that children make to the nation that was prioritised in the policy documents at the other end of the spectrum. This highlights how problems and solutions are framed in different ways, depending on the underlying assumptions in policy.

4.5 Silences within the policy documents

In addition to answering the research question on the recognition of Indigenous rights, this analysis has highlighted silences within the policy documents. Much of the literature previously reviewed in Chapter 2, refers to the trauma of past policies where Indigenous children were forcibly removed from their families. I have explained that in Australia, Aboriginal and Torres Strait Islander children have continued to be removed at 9 times the rate of non-Indigenous children (Lindstedt et al., 2017), and that Wahlquist (2018) reported the total number of Indigenous children in Australia in out of home care has doubled in the last decade. The Australian Institute of Family Studies (2019) reported that the over representation of Aboriginal and Torres Strait Islander children in child protection is caused by past policies and the legacy of colonisation. I noted that they refer to poverty, assimilation policies, intergenerational trauma and discrimination as complex factors that contribute to the growing number of children at risk and being removed. These underlying causes of inequity are silences in the CTG policy documents.

A CTG target that specifically relates to early childhood is for all Indigenous children to be enrolled in early childhood education by 2025, and the Australian government claimed that we are on track to meet this target (Commonwealth of Australia, 2019). However, this policy analysis showed that there are silences within the policies on early childhood education. Engagement, and important social determinants of Indigenous health such as language, culture and identity are not included in strategies within policy. This reveals an assumption that enrolment in early childhood education will directly link to improved educations outcomes. While enrolment is likely to be an important first step in increasing access for Aboriginal and Torres Strait Islander children to education, it doesn’t consider how children and families will be supported and whether the services provided are culturally safe.

The other CTG early childhood target is to halve the gap in child mortality by 2018 and it is reported that this is not on track (Commonwealth of Australia, 2019). According to the Prime Minister’s CTG report in 2019, the factors associated with Indigenous child mortality are both biomedical (perinatal conditions, pre-term birth, low-birth weight, maternal diabetes) and behavioural (smoking, alcohol and drug use). In addition the report draws on research by the Australian Institute of Health and Welfare (2014) and the Australian Health Ministers' Advisory Council (2017), concluding that the complexity of child mortality “highlights the importance of focusing on improving access to culturally appropriate maternal health and pregnancy-related care, as well as broader health initiatives as these help lower the risk factors for poor birth outcomes" (Commonwealth of Australia, 2019, p. 38). However, literature showed that mainstream health services are less likely to be culturally safe and that they can resemble past policies of assimilation and normalisation (Cooper, 2011; Klein, 2015; Smith, 2007; Sullivan, 2011). The lack of policy strategy to support self-determination where services are provided by Indigenous communities for their communities, is a silence within the CTG strategy. Only two of the policy documents in this analysis document the important role that Aboriginal Community Controlled Health Organisations can play in leadership and the provision of culturally safe health and education services (NASTIHP policy #4, IP-NASTIHP policy #7). This silence reflects a disconnect between a policy focus on biomedical and behavioural causes for child mortality, and the need for strategies that support social determinants of Indigenous health.

Considering that most of the policy documents only implied Indigenous rights, or Indigenous rights were ignored, the lack of Indigenous rights in policy is, also a silence. As previously noted, it is impossible for the CTG policy documents to fully recognise Indigenous rights because of the political context where there is no treaty between the Commonwealth and Aboriginal and Torres Strait Islander people, and no constitutional recognition of Indigenous rights in Australia. The lack of policy strategies in support of self-determination and Indigenous rights are therefore a reflection on the political context. The power imbalances, deficit framing, and problem representations identified through this policy analysis in documents such as the Indigenous Advancement Strategy (policy # 12) are consistent with the ongoing legacy of colonisation. The power imbalance of the Commonwealth over Aboriginal and Torres Strait Islander people is seen through policy strategies that incorporate specific targets for Indigenous children and families through education and the provision of health services, but they are situated within a mainstream model. This supports universal human rights but can ignore or undermine Indigenous rights, maintaining power imbalance and resisting decolonisation.

Finally, an understanding of childhood from an Indigenous knowledge perspective is also missing from the CTG policy documents. The role of children as an Aboriginal family's greatest asset (D'Antoine and Bessarab, 2011) and the collective approach to parenting (Geia, Hayes and Usher, 2011) is not prioritised within the early childhood health or education policies. Therefore, I have identified Indigenous perspectives on childhood as a silence within the CTG strategy documents.

4.6 Chapter Summary

In answering the first research question, “To what extent are Indigenous rights prioritised within the CTG strategy on early childhood?”, this analysis has shown that some policies recognise Indigenous rights to a greater extent than others, but no policy fully realises the rights for Indigenous people. All the policies refer to social determinants of health but as a package of CTG policy documents related to early childhood, they do not consistently prioritise social determinants of Indigenous health. There is a clear focus on the provision of services through a mainstream model rather than the promotion of self-determination, even though this is an Indigenous right and is important for health. This policy analysis has identified problem representations, deficit-based approaches, and silences that need further exploration. The silences indicate growing gaps between Aboriginal and Torres Strait Islander and non-Indigenous child removal, and inconsistent policy strategies to build social determinants of health and address inequities. In addition, the lack of self-determination within the policy strategies showed that the CTG strategy has many inconsistencies regarding principles of decolonisation.

CHAPTER 5: SHEPPARTON CASE STUDY

In this Chapter I report on findings from the Shepparton case study. The results are drawn from my experience visiting the region, documents relating to history and current operation of organisations in the region, and interviews with participants in government and non-government sectors in health and education. Eleven participants identified as Aboriginal and Torres Strait Islander and 5 were non-Indigenous. In order to protect the anonymity of participants, quotes are not linked to any identifying feature other than Aboriginality when necessary.

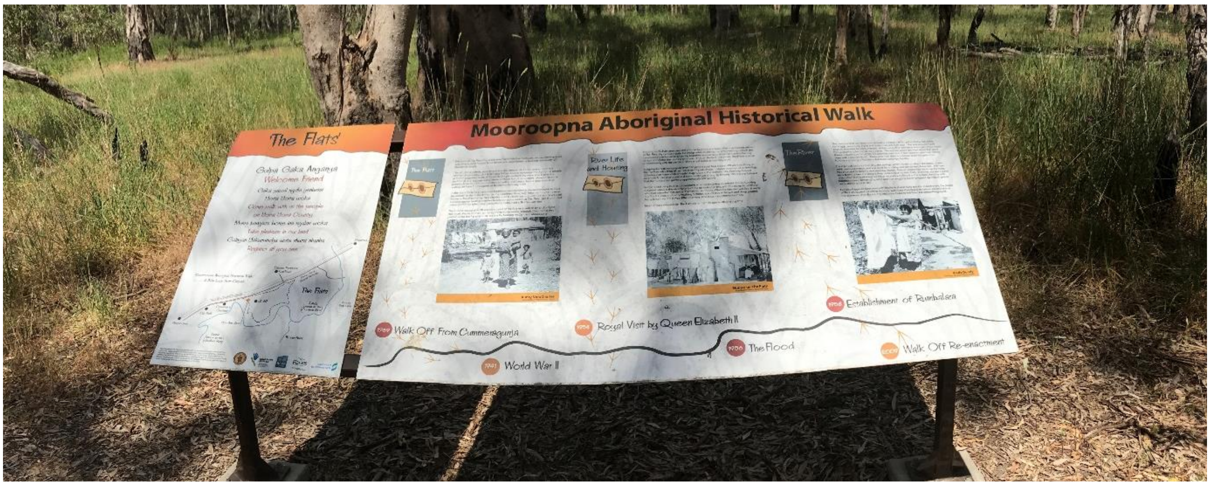
I begin with an overview of the Shepparton context including the legacy of generations of leadership and advocacy among the Aboriginal community in the Goulburn valley region. Following this, I provide a summary of the current health concerns and services in the region for people and community. Then I draw on the themes that emerged from analysis of the interview data in Shepparton, and discuss participants' understanding of Closing the Gap (CTG) policy implementation in early childhood.

5.1 Shepparton History and Context

Shepparton and the neighbouring town, Mooroopna, are major population centres for Aboriginal people in the Goulbourn Valley. Locally known as "Koori", Tynan (2007) explained Aboriginal people in this region have a "strong common identity strengthened by extensive kinship ties and a shared history of struggle, including ongoing experiences of racism" (p.278). The Yorta Yorta and Bangerang people are the traditional owners of the Shepparton region.

The recent history from the 1930s of Yorta Yorta and Bangerang people reveals the generations of advocacy and leadership that opposed assimilation and fought for Indigenous rights, ultimately leading to the establishment of Rumbalara Aboriginal Cooperative, among other achievements. Visitors to the area can learn about the history through the Mooroopna Aboriginal Historical Walk. In 2011, signage was installed along a path from the Midland Highway to "The Flats" of Kaiela, known in English as the Goulburn River (River Connect, 2011), as shown in Figure 6.

Figure 6: Mooroopna Aboriginal Historical Walk, Shepparton case study (Photo by Emma George)



In 1939 up to 200 Aboriginal people “walked off” the Cummeragunja Mission to protest the restrictive control, poor rations, cruel treatment and removal of Aboriginal children from their families (Green Left Weekly, 2019; Rumbalara Aboriginal Cooperative & Inception Strategies, 2018). Leader Jack Patten sent a telegram to the state Premier informing him that Aboriginal men and women were leaving the Cummeragunja reserve due to intimidation, starvation and victimisation, and he demanded an immediately inquiry (Davis, 2014). Grandson of Jack Patten shared,

> “I think about my grandfather, who had the courage to lead his people off [the mission] and away from the atrocious conditions that he has his people were subject to. They already had generations and generations of children being taken away… So grandfather came. He instigated the walk off, he got arrested for this troubles” (Green Left Weekly, 2019).

Dr Wayne Atkinson, a Yorta Yorta elder, remembered that there were many men and women who fought for human rights that were being denied to Aboriginal people and forced to live under segregation and control (Green Left Weekly, 2019). In the media, the walk-off was described as a strike or exodus which is in contrast to the description in Aboriginal memoirs of reclaiming land that always belonged to them. “The descendants of the Ulupna, my mother’s tribe, the Yorta Yorta, Wirrardjeri and other tribes – mothers, fathers, babies, children and elderly people – all tracked across the same land that had belonged to us in our tribal days” (Tucker 1977, cited in Davis, 2014, p. 128). A camp was established on “the Flats”. At that time, the river was clear and food was in abundance. Flooding occurred most years therefore when required, people took refuge on higher ground. People lived in dwellings made of tin or fabric tents. Aunty Hyllus Briggs taught the school children in an open-air classroom depicted in Rumbalara Children’s Story Book as a ‘bough shed’ as shown in Figure 7.

Figure 7: : Rumbalara Open-Air Classroom (Rumbalara Aboriginal Cooperative & Inception Strategies, 2018, p. 8).

Image removed from thesis. See document at link: Rumbalara Our Story

By 1946, there were 130 people (age 8-80) living on the Flats. Meals were mostly prepared on outside fires but some families had an inside stove with a chimney. When the weather was bad, it was difficult to keep dry and the damp conditions made it difficult to prevent illness, particularly pneumonia. According to the signs along the walking track, people who lived on the Flats remember "life has hard, but a happy time" (River Connect, 2011). Rumbalara Aboriginal Cooperative (2017) explained that by the 1950s, approximately 300 people were living on the Flats in challenging conditions. In the lead up to the 1956 Melbourne Olympic Games, the local policeman stormed the camp and hid the established shanties with hessian bags. The purpose was to shield Queen Elizabeth II and the Duke of Edinburgh Prince Phillip from the community when they drove past on their visit to the region. The attempts to hide the community from the Queen were in vain as parts of the screen had fallen. Our guide on the historical walk explained that children had climbed over the screen to catch a glimpse of the Queen and to wave, so they caught her attention. On seeing the inadequate living conditions, reports indicate Queen Elizabeth said it was not safe for children and families and that proper shelter should be provided (Rumbalara Aboriginal Cooperative & Inception Strategies, 2018). Following this, in 1958, the Flats were deemed an unhealthy environment and the Aboriginal Welfare and Board and Housing Commission erected 10 prefabricated houses at the current Rumbalara site. Each house was constructed entirely out of concrete with no hot water or sewage until 1964 when the houses were extended to include a bathroom, lavatory and laundry. One of these buildings has been maintained and preserved as a museum as shown in Figure 8. These houses were never intended as permanent accommodation but a step towards rehousing families within the broader community, and by 1969 most Aboriginal families had been re-housed and the concrete dwellings were closed.

Figure 8: Prefabricated house maintained on site at Rumbalara, Shepparton case study (Photo by Emma George)

In the 1970s, the Goulburn Murray Aboriginal Cooperative fought to obtain the rights to the Rumbalara site and prevent it being sold to a youth group (Rumbalara Aboriginal Cooperative, 2017). Their persistence and advocacy resulted in the Rumbalara site acquired for a nominal sum with the intent to establish a place where “our Community could provide an extensive program for our people, who could also meet there for cultural and social activities” (Mooroopna Aboriginal Historical Walk, 2016). Finally in 1981, a medical clinic was established at the Rumbalara site to provide health services for the community and it continues today as an Aboriginal Community Controlled Health Organisation (Rumbalara Aboriginal Cooperative, 2017). The Rumbalara site now hosts a collection of buildings providing a range of services. The growth of the ACCHO was celebrated with the addition of the “Harmony Centre” which overlooks the scrub and has hosted maternal services as well as a conference room for large events as shown in Figure 9.

Figure 9: The 'Harmony Centre' at Rumbalara (Photo by Emma George)

In 2009, a group of Aboriginal people re-enacted the Cummeragunja walk-off. Davis (2014) reported that the walk began at the station and finished on the flats at Mooroopna, more than 80 kilometres away. The 16 hour walk symbolically represented the journey Aboriginal people had made away from mission life into life within the Goulbourn Valley. The Cummeragunja walk-off was remembered as an event that inspired Indigenous people across Australia to advocate for their rights (Fletcher, 2009). The legacy of the Cummeragunja walk-off and the decades of advocacy which followed, laid a foundation for the Aboriginal controlled organisations and services in the region.

5.1.2 Rumbalara Aboriginal Cooperative

The Rumbalara Aboriginal Cooperative is one of the largest providers catering to the needs of Aboriginal and Torres Strait Islander people in the Greater Shepparton area. Key health issues that impact the local Aboriginal community inequitably are cardiovascular disease, diabetes, kidney disease, smoking, obesity and overweight, asthma, and mental health issues (Rumbalara Aboriginal Cooperative, 2016a; Rumbalara Aboriginal Coorperative, 2016b). In addition, family violence and drug and alcohol abuse have been identified as issues with 'ice' displacing alcohol as the biggest drug problem in regional Victoria (The Age, 2015). Rumbalara reported that while 'ice' and alcohol remain present in the community, heroin along with other new stimulants are emerging (Rumbalara Aboriginal Cooperative, 2016a). Research by Rumbalara identified that community has a skewed understanding and experience of health where being unhealthy is considered to be the norm.

> "We believe that the community has become so used to living in sub-optimal conditions, that this has become the new norm, and that this encompasses physical, mental, cultural, spiritual, educational and economic wellbeing. This is because of an historical environment of trauma and disadvantage that has been experienced by multiple generations who have normalised a state of being unwell" (Rumbalara Aboriginal Cooperative, 2016b, p.25)

In 2017, 1373 Aboriginal and Torres Strait Islander people were active patients of Rumbalara, accessing services two or more times in a 24-month period. This represents 66% of the region's Aboriginal and Torres Strait Islander population. The organisation employs over 200 staff with an annual budget of approximately $20 million (Rumbalara Aboriginal Cooperative, 2017). Services provided include:

- Medical clinic
- Oral health services
- Hearing program
- Social and emotional well-being services
- Alcohol and other drugs services
- Family services
- Housing
- Financial and administrative services
- Justice service (including family violence services, youth culture program, night patrol, youth justice services, mentoring, and the Aboriginal community justice panel program)
- Aged care and disability services (including home and community care, respite care, and aged care services).

Rumbalara recognised that there are challenges managing the operations of an ACCHO, particularly with regard to governance over finance, risk management and program performance (Rumbalara Aboriginal Cooperative, 2016b). In the 2015-2016 Annual report, it is recorded that the organisation went through significant change to address a lack of financial knowledge resulting in clearer reporting and enhanced management. The chairperson called for support from the community and acknowledged that despite progress as an organisation, there is "a constant battle to address the lies, smears and innuendo that constantly circle in the community and which disallows true unity" (Rumbalara Aboriginal Cooperative, 2016a, p. 2). Between 2016 and 2020, there have been 4 different Chief Executive Officers at Rumbalara. Research participants reported that the disruption to the overall management of the organisation has not interrupted access to health and community services provided by Rumbalara. None of the participants raised leadership change as an issue in this study. As an outsider, I was not able to probe more on the impact of leadership change and I offer some reflection on this in Chapter 9.

5.1.3 Lulla’s Children and Family Centre

“Lulla’s” is a Multi-functional Aboriginal Child Care Centre, managed by Aboriginal community to meet the educational, social and developmental needs of Aboriginal children (Victorian Aboriginal Education Association Inc, 2012). The centre was established by bringing together two services, the Lidje MACS Child Care service based at the Mooroopna site, and the Batdja Preschool and Child Care Service in the town of Shepparton. The services were amalgamated based on a philosophy of making education accessible and welcome to Aboriginal families (Atkinson, 2010). Lulla’s exists so that all Aboriginal children have the opportunity to reach their potential through early childhood programs that reinforce cultural identity, self-esteem, self-confidence, and provide a foundation for life-long learning (Lulla's Children and Family Centre, 2016). The centre is named after a local Aboriginal woman Esmerelda, affectionately known as Lulla. An old photograph of Lulla as a child adorns a wall of the original concrete fabricated house located at the Mooroopna site. As explained by community, she had 14 children and one of her biggest passions was education. Lulla knew that education could lift her family out of poverty. Some of Lulla’s children only completed education up to grade 6, but others went on to become doctors and corporate managers. To honour her memory and her love of butterflies, the centre is adorned with many butterfly images.

5.1.4 Rumbalara Football and Netball Club

The influence and legacy of Aboriginal people in Shepparton and Mooroopna extends beyond health and education. The Rumbalara Football and Netball club (Rumbalara FNC) history dates back to the 1800s (Rumbalara Football and Netball Club, 2019). Aboriginal people living at the Cummeragunja mission played a game known as “Marn Grook’ but they quickly learned how to play an Australian brand of football. In the 1920s an Aboriginal team known as “The Invincibles” won six premierships in 11 seasons until they were forced to withdraw as the league banned players over the age of 25.

After the Cummeragunja walk-off, people continued to play football and in 1946, an Aboriginal team played in the Central Goulbourn Valley League and won the second division. They were expelled the following year. For the next 4 decades Aboriginal footballers continue to fight for inclusion without success. Doyle et al. (2013) explained there was "opposition from other clubs based on purported inadequacy of facilitates, perceptions that Aboriginal players were "bullies", and other negative racial stereotypes promoted by mainstream media" (p.9). It wasn't until 1997 that the Rumbalara FNC was invited to join a restructured regional league and the following year, on the centenary of the first grand final win by "The Invincibles", the club's senior team won the premiership (Rumbalara Football and Netball Club, 2019). Tynan and Briggs (2012) noted that from 1997 onward, there has remained ongoing discomfort and prejudice with some clubs not respecting Rumbalara FNC as equals. They explained that "Rumbalara's experience of contemporary expressions of racism has been and is quite profound… this is evidenced for example in its struggles to achieve sponsorship levels, that is, market the 'Aboriginal brand' locally, similarly to other clubs" (p.201). Despite the challenges, Rumbalara FNC has grown to now have four men's football teams, a women's football team, and eight netball teams from juniors to seniors (Rumbalara Football and Netball Club, 2019), but the Rumbalara FNC is more than just a sporting club. They also promote health and healthy lifestyles, social inclusion and community building (Australian Government, 2012). Doyle et al. (2013) argued that the Rumbalara FNC make a major contribution to addressing health inequity through a "holistic view of well-being, nutrition and physical activity that incorporates the social determinants of health" (p.16). Local community expressed that there are links between the FNC and Rumbalara Aboriginal Cooperative as their share a rich history and commitment to health and well-being. I observed this overlap as staff from Rumbalara Aboriginal Cooperative are players, coaches and administrators at the FNC, fostering participation in health and well-being programs while also supporting the community love of sport.

5.2 Case Study Results

Seven key themes emerged from the data following interviews with participants:

1. Rumbalara is more than a service provider
2. Structural constraints in policy implementation
3. Describing partnerships in policy implementation
4. The disconnect between policy and implementation at the local level
5. The influence of policy actors in implementation
6. Understanding self-determination and leadership
7. The right to an Aboriginal childhood

5.2.1 'Rumbalara' is more than a service provider

Rumbalara Aboriginal Cooperative (Rumbalara), and the other service providers in the Shepparton region are all key stakeholders in implementation of CTG policy. Participants readily identified that the Rumbalara provides a wide range of services for the community and has a key role in the implementation of the CTG strategy in the region. Rumbalara's holistic approach to care of families and communities supports early childhood development but in interviews, participants did not limit their views to early childhood policy implementation specifically. Participants were cognisant of Rumbalara's history of resilience, and that this history has provided a foundation for the community and other organisations in the region. The deeply rooted respect shown by participants with regard to history suggested that Rumbalara was much more than just a service provider. One participant said "it's important that Rumbalara exists, to help connect people to their culture and the history not only of Rumbalara but the history of Aboriginal people in general". This history and connection were seen as a source of strength by participants. "There can't be a strong Shepparton without a strong Aboriginal community and a strong Rumbalara". The connection between Rumbalara, culture and identity were described as inseparable. Another participant stated that "Rumbalara in itself is culture... we never want to lose our cultural identity, ever, so we always make sure that whatever we do, it always has, you know, us as part of it". The importance of culture as a determinant of health and that sense of belonging to Rumbalara was identified as something unique for Rumbalara that other services in the region could not replicate. Rumbalara was described as "a gathering place, a meeting place, you know, connection". A non-Indigenous participant explained that other services have "a beginning, a middle and end with clients, that's it, but your connection to Rumba might be lifelong, in varying ways". It wasn't just the range of services provided by

Rumbalara, or the physical location at the Mooroopna site, that enabled a deep connection with many parts of the community. Participants also highlighted the importance of services that are “working with our people for our people”. Another participant explained, “Knowing your people, knowing your community, knowing the types of issues that affect your community, you know, what motivates your community. From an organisational level I guess that’s what makes Rumbalara different to, say, what a mainstream organisation can achieve with our people”. Participants clarified that this ensured services provided by Rumbalara can respond to “issues present within the community… health issues, social issues, economic issues”. Therefore, the benefit of Rumbalara’s services move beyond medical or educational targets, to a richness that is deeply connected to community. In addition, all participants recognised that services provided for Aboriginal people, by Aboriginal people are culturally safe. As one noted: “No one else knows how to be more culturally appropriate than ourselves”.

5.2.2 Structural constraints in policy implementation

Participants from a variety of organisations described structural constraints linked to complex funding arrangements. Participants explained that funding for programs come from a range of state and federal government departments. Not all services are funded directly through CTG national partnership agreements or the Indigenous Advancement Strategy (IAS), although much of the work of these organisations contributes to closing the gap in health inequities and reaching the CTG targets in health and education. For example, health checks included within the education sector were provided without direct CTG funding but in response to community need. One participant from Education explained “us doing health checks for Aboriginal kids within our schools – we didn’t even consider it as a Closing the Gap initiative, we just considered it as something that needed to be done, but in the scheme of things it probably is one, and it is a good one.”

Most participants viewed government as “the funders”. One participant explained “So, resources get put in. That’s what government does. They look at who they think the real problem areas are, they focus on putting support and money there.” Participants described the complexity of working with local, state and federal governments as a challenge. One participant explained CTG policy implementation as a “scattergun approach” where one program might work well in one part of the state, but then not in another, but implementation is scattered across the region. I interpreted this to mean that the overall approach to policy implementation can be inconsistent and unreliable. One participant managing several funding sources described juggling reporting requirements as a challenge and said “so are we meeting targets? Are we spending the right amount? Are we on track to clear the funds by end of June? It’s just massive.” Rumbalara’s research paper documented that the “reporting, administration and compliance focus demands that much of our resources be specifically allocated to this function. This has resulted in Aboriginal Health and Community services being forced to conform to the needs of the funding bodies, policy makers and political cycles at the expense of the care for our clients” (Rumbalara Aboriginal Coorperative, 2016b, p. 26). In addition, one participant explained “they have their eye on us. It isn’t explicitly out there but the lack of trust is something felt. The lack of trust from government and public opinion is a driver for this over-reporting. We are fostering open communication and share different developments and networks [but] trust goes both ways”. In response to the overburden of reporting, managing complex funding arrangements and a perceived lack of trust, participants from non-government organisations expressed a preference for dealing with fewer lines of reporting or just one level of government “because it’s just so confusing”. In addition, the competitive tendering process for funding under the IAS was described as “a competition that we don’t want to be a part of but are a part of.” In a follow-up workshop, one participant described the competition for funding as “survival of the fittest”. The IAS line of funding in particular was a source of frustration for service providers because it appeared to be disconnected from the needs of local communities and communication between levels of government was not clear. One participant explained “I just think that because [the IAS is from] federal government I don’t really think there are things in place for them to work very well with the states… Look at the IAS funding. It was never thought through... It wasn’t delivered really well”.

Participants expressed concern over the insecurity of funding which creates “insecurity for staff and instability for organisations”. During follow-up workshops, participants from Shepparton explained that discontinuity in funding has a cost beyond the financial insecurity. They explained that every time there is a “break or slip, or stop and start” there is an impact on relationships, workforce development, stakeholder engagement and community trust. Participants agreed that there is a cumulative impact on the community because services may disappear for a while and then people are apprehensive to reengage in those services when it returns. Participants from non-government organisations felt that community assumed the problem was something for service providers to address rather than it being a problem in policy. This puts additional strain on the service providers who are implementing policy, wedged between funding issues and potential community discontent. In response, participants from the Aboriginal health sector dreamed of funding for community building, health promotion and strength-based initiatives. One noted “it would be great to have a bucket of money to purely focus on promotion and prevention” which would be less prescriptive, and more responsive to the needs of the community. A further person advocated that “realistically, health should be about prevention rather than management. We do a good job with the resources we have but to have a bucket of money to run programs constantly, connect with schools, would be good”.

5.2.3 Describing partnerships in policy implementation

Some of the non-Indigenous participants described a partnership approach to working with Aboriginal organisations and communities. For example, one non-Indigenous participant from a non-government community-based organisation stated “we’re going to stop doing things to Aboriginal people, we’re going to do things with Aboriginal people. I think that’s a sensible reframing and that’s something that we should’ve been doing all along”. Another non-Indigenous participant from within the government sector suggested that partnerships need to be more than an agreement on a piece of paper. “The partnership has been formalised through documentation. We have a very good relationship going back over 20 or 30 years. The Department has to negotiate in relation to policy... It’s not just a partnership in name.” They identified that commitments needed to have actions associated with the promises of partnerships. A third participant explained that partnerships are “about working inclusively with other organisations and building relationships there is really important. When that happens, you are able to do things a whole lot better.” However, from an Aboriginal perspective, participants described having to repeatedly exercise tolerance and patience with non-Indigenous policy actors claiming to want to work in partnership but seeing community-controlled organisations as merely instrumentally useful to government policy goals, rather than engaging in a genuine, two-way partnership. One participant explained “You have to learn to balance [and] extract the emotion completely… you have to be neutral and mindful not to judge… if you heard in the past they were not very supportive, you have to go in to that meeting knowing how to move forward. It’s a balancing act”. The non-Indigenous narrative of “working with” Aboriginal and Torres Strait Islander people and communities was not considered by Aboriginal participants working in early childhood to be a new approach, and partnerships were seen to be more rhetorical than substantial. Therefore, these Aboriginal participants were sceptical of how such relationships would be actioned in policy implementation. A clear frustration expressed by participants from the Aboriginal health sector was with the lack of accountability for non-Indigenous service providers who were funded through the IAS but did not have strong connections with the local Aboriginal community. They said “if you’re applying for Indigenous money what are you actually doing? … Don’t just say tick the box and not do anything, you’ve got to actually be proactive”. In this example, Aboriginal leaders expressed that “working with” Aboriginal people needs to be more than reporting that you met with someone or have an Aboriginal advisor to oversee programs.

All participants were asked who they thought was responsible for closing the gap in early childhood and there was overwhelming support from all participants for a collaborative approach where “everyone” is responsible for addressing health inequity in Australia. One participant explained, “If we don’t all work together, we’re not going to close it. We all need to be responsible for it”. Another participant supported this notion, “It’s government, it’s the organisations; it’s everybody. Without one you can’t close the gap.” While all participants spoke of partnership with some aspiration, some also indicated that with collective responsibility to close the gap, no one ends up being accountable for progress. One participant said that “there’s no particular butt kicking [in policy implementation], it’s more a collective hand wringing of ‘we could do better on this and we’ll try harder’ and that, to me, is a feature of pretty much every single Closing the Gap report for the last nine years”. Another participant explained “one of the wicked problems of the bureaucracy is that collective responsibility inevitably ends in no-one being responsible… ‘hey, it’s not my problem; it’s someone else’s problem’ so how do you get that balance right in the Closing the Gap space is a particular challenge I think”.

Participants identified a barrier to partnerships and this collective response to closing the gap as the nature of the relationship between government and the organisations implementing policy in the community. This relationship was described by an Aboriginal service provider as “very much a servant/master relationship” because “it’s the government who always says what’s best for us, so there you go”. Another participant suggested that “government are still the puppet masters directing what’s being said and where money goes. That’s what they do”. Even in the community control sector, the role of government seemed to be overpowering as one participant explained “100 percent of our funding comes from government and [tied] to that funding are contract obligations, so for a community to think that they can influence how the deliverables of a contract can be changed is delusional and there is no community controlled in that aspect”.

Furthermore, participants identified the limitations in consultation whereby government claim to have connected with community and early childhood services, but this appears to be superficial. For example, “they say ‘we did lots of consultation’ and I’m like ‘did you come out here and speak to my staff? Did you come out here and speak to my families? Did you come and speak to nan that’s got six grandkids because mum and dad are on drugs?’ ‘Oh, no’. They’re the stories that they need to hear.” These frustrations regarding the lack of insight from government about community issues and the complexity of policy implementation in early childhood was also prevalent from service providers. One participant explained “something that I always say to government people, that when they tell me that they’ve been to see me I’ll say ‘when did you?’ or they’ll say we had a session in Geelong that I should’ve went to and I’m like ‘but I’m in Shepparton driving the bus, cooking in the rooms if staff are away. Like I’m just not sitting at my desk all the time; there’s a lot that goes on in the day to day service here’ so yeah”.

5.2.4 The disconnect between policy and implementation at the local level

Participants expressed discontent with governments funding programs that do not address the most important local issues. For example, a participant from a non-government organisation explained “you might get funding for [children’s] ear health, right, whereas in Shepparton issues with your ears isn’t a huge problem in our population here. You know, ours might be more around specifically diabetes so we need lots of funding around diabetes, prevention, management, all of those sorts of things”. This disconnect was also identified by a participant from the government sector who said “we fund all of the issues that are prominent here in Shepparton and in our community, but we don’t get specific funding for those things, or we don’t get a big enough amount of funding to tackle those issues that are specific to our community – they’re trying to be like one size fits all”. This “one size fits all” in early childhood and more broadly across the CTG strategy became clearer as participants discussed the disconnect between metropolitan and rural policy implementation. Most of the participants agreed that what happens in Shepparton is different to what would happen in the state capital city of Melbourne and yet, they thought that policies did not reflect this context. One participant explained “What works in metropolitan Melbourne, it’s great, good policy works there. When you try and implement it in a rural context you go “that’s going to be hard.” Another participant advocated for increased local control over how resources are used which would reduce the disconnect between policy and implementation at the local level. They said:

> "some knucklehead 25-year-old with a masters degree sitting five kilometres from the centre of the CBD isn't going to have the answer. The answer is going to sit here in Shepparton… and the answer's going to be different for every community because the community will design the solution that they're capable of delivering."

With the lack of context-specific responses to local issues in health and education for children, participants felt that the reporting on CTG targets is inaccurate, that the government is measuring the wrong things, or that the process of monitoring and reporting is flawed. One participant explained "they've maintained these key performance indicators and never actually brought them together and then looked at the social aspect of that as well. It was always set up to fail." Another participant indicated that the targets were never set to measure attainable progress. They said "government have unrealistic expectations… I suppose, an assumption of white middle-class educational attainment onto a community that can't live up to that assumption." Another participant described this "white middle class" as "the ruling population" and that implementation of the CTG policy has not "understood what has to happen within an Aboriginal community to really engage with closing the gap". One participant suggested that these flaws in measuring the CTG targets maintain "silos" of power whereby money is given, money is spent, but community is not really engaged in the conversation. An Aboriginal participant explained it results in "a one, two, three- or four-year cycle of funding to effect generation change [which] is ultimately pointless…it actually [requires] a collaboration over time… and that type of investment is too scary for people".

Some participants reflected that CTG policy did "not embrace Aboriginal ways of thinking" and "I think it is going back to an assimilation policy". One participant explained "I don't have a problem with [CTG] but I do have a problem with how it's delivered. Are we really closing the health gap because it's feeling like a bigger gap… over the last 16 years, I've said this several times?" When participants were asked what improvements in health could look like in the next decade, they referred to closing the gaps that exists outside of the CTG strategy. One Aboriginal participant explained that "I would love to see [life expectancy] increase… but there's a lot of things I would like to see happen in my community in the next ten years or so… I would like to see my community happier and more cohesive… [addressing] the hurt and trauma [that] affects us being able to interact as a close-knit community… that would help people's health and well-being". Another Aboriginal participant said "Obviously you want to see the [CTG] KPIs and that physical health stuff start to close… [but also] to address mental health, substance abuse and social wellbeing. I think we need to achieve proper community connectedness". For children, participants recognised the importance of targets in mortality and education but that these targets did not always represent the underlying issues or the importance of social determinants of Indigenous health. As one participant explained "I would love to see more of our culture being taught… focus on the beauty of our culture and really embed that so that it gives [children] a sense of belonging, a sense of identity, because that loss of identity is one big factor that affects communities today".

Another Aboriginal participant explained that when Aboriginal children have to be removed under child protection in the Shepparton region, they often move away from country. This participant feared that children will lose their sense of culture as a result. In my field notes I reflected on the passion of many of the Aboriginal participants to ensure that children in the Shepparton region have opportunities to develop a sense of identity as an Aboriginal child. Neither the increasing rates of child removal, or the support for building cultural identity were measured by targets in the CTG strategy at the time of the interviews.

5.2.5 Influence of policy actors in implementation to promote an Aboriginal view of health

Despite the structural barriers in implementation, participants – as policy actors – were able to have influence over policy implementation to some extent. This was most clearly seen in the work of Rumbalara where "our programs, services, are designed to work specifically with the needs of the community". Participants who worked with Rumbalara described how their approach aligned with an Aboriginal understanding of health and well-being. For example

> "what we're looking at is that we need to value all of the domains equally so that connection to country and the health of country and your ability to identify who you are and trace your lineage back and get strength back from your traditions is just as important as earning money or taking the right medication for the right length of time. If you truly feel healed from a smoking ceremony or from sitting down, having a cup of tea with an old aunt somewhere, then that is as valuable a part of your therapy as talking to a counsellor".

This Aboriginal understanding of health is broader than a biomedical approach as it incorporates culture, identity and belonging as important determinants of health. One participant clarified that this is not a new approach to health, but that an Aboriginal understanding of health has always been important and essential for health and wellbeing for individuals and community. They explained that throughout history

> "Everyone had their place, and everyone contributed... It's like in the ecosystem with cultural traditions on the river [where] the tribe up the river is responsible - is actually responsible for the tribe down the river because everything they put in the river, everything they take, all their actions filter down and can affect the tribe down, so everyone's responsible for everyone".

This collective, relational understanding of health underpins the flexibility shown by people working within community-controlled services to bend implementation in response to the needs of the whole community. Participants explained that if implementation was to stay within the intended boundaries, then "ear health" programs would be run without also addressing more prevalent issues for the local community such as diabetes. One participant explained that when a community member comes to Rumbalara for a health check, the service provided is not just about taking "blood pressure… and off you go… It's 'how are you today, what's all the issues going on? What about the child? What about this?' We are encompassing the holistic model of the whole family rather than this is what I'm billing [for] and this is what I'm going to do". In addition, staff from Lulla's explained that health checks were being conducted at the children's centre, providing an example of how policy actors can influence policy implementation to best serve the community.

Another example of the influence of Aboriginal participants in this study over policy implementation is in the way that Indigenous knowledge has been embedded into education. Language was identified by participants as an important part of storytelling and building a sense of identity. One participant explained:

> "We've got to start putting [language] in education, we've got to start injecting that cultural curriculum. Languages are dying. Over half the languages of Australia are extinct now. How do we bring that back? We start by teaching them a couple of words and going from there".

Another participant described a shift in focus to ensure language remains part of learning and identity for Aboriginal children. They said:

> "language is becoming more readily available. We've got people who've learn language and are now able to then start teaching and passing it back down again. We are providing opportunities for kids to start learning language… and it gives a real sense of pride too when you're hearing our language being spoken again".

In addition to the focus on language, one participant explained how Indigenous knowledge is embedded within early childhood services, saying:

> "we embed some cultural content … so children know that they're on Yorta Yorta country here and what does that mean and who's a Yorta Yorta person that we know, or they can name and then identify maybe some of the significant landmarks around the area… We teach them how to make particular traditional artefacts… We have elders who can come and speak and sit and talk to children or we involve elders in some of the decision-making processes that we have to make around children and what's in the best interest of the child."

These actions and decisions made by service providers on how services are to be delivered, demonstrate how Indigenous knowledge has been prioritised. The same participant went on to explain how important this knowledge is for understanding culture and building identity. They said:

> "In the kindergarten what they sent out at the start of the year was 'who's your mob and where do you come from?' and so that's leading up to when they graduate… and they'll receive a kangaroo skin with the kid's totem and where they're from and their name as a parting gift. Then they'll feel proud of what – you know, where they come from because… it's song and it's art and it's having visitors come in, elders come in and talk to them."

This sense of identity is an important social determinant of Indigenous health that is not a target of the CTG strategy but something participants understood as essential for health and well-being, and providing a foundation to achieve the CTG targets in health and education. Other examples of Indigenous knowledge embedded into early childhood services included Bush Kindergarten activities at the Rumbalara Mooroopna site where children learn and play on country. When I first visited the site, diagrams of art and nature were still on display and staff explained that before the children play in the bush, an Elder teaches them what is safe and how to connect with country. Rumbalara describe this as an unstructured form of nature play where children build their own cubby houses, paint and collect natural objects, leaves and rocks (Rumbalara Aboriginal Cooperative, n.d.).

5.2.6 Understanding self-determination and leadership

Participants were asked what they thought self-determination meant and how was it enacted in Shepparton. A consistent response from all participants was that self-determination was limited by the structural power imbalance of government over organisations and community. Participants described self-determination as a "journey that started 200 plus years ago, and it continues to this day”. One participant outlined that there is an “aspiration of the Victorian government” to agree to a treaty with Aboriginal people and while there has been hope for progress, “timelines for the treaty keep getting pulled back… I think the complexity of what’s involved and the kind of community consultations that have occurred are highlighting a whole lot of challenges about moving towards that and therefore rather than rush, people are taking their time about it”. Another participant explained that self-determination should result in Aboriginal communities determining solutions for themselves. This would be reflected in “policies that are developed to suit the community’s needs, not what’s good for your own government or the political cycle or whatever, but really looking at the problems and coming up with really good solutions”. In the absence of treaty or self-determined policies, a participant described “self-determination as being able to take the lead”. For some participants this meant that individuals have choice and options regarding their health care and education, either through Aboriginal controlled services or accessing services in the mainstream. For service providers, leadership meant having influence over the way that policy is implemented despite the policy and funding limitations. To expand on this idea of leadership, participants were asked what they thought good leadership looked like. Participants described a style of leadership that is collaborative, connected to community, humble, grounded and built upon strong teams. One participant said “See I like to use the metaphor there’s a big pie and to say your pie is your directorate and everyone is responsible for a piece of it. No-one’s higher and no-one’s lower but everyone just has different responsibilities and different roles within that, whether it be big or small, but we’re all there to achieve the same things, all there to support each other.” This collective style of leadership with leaders working alongside teams and community was common among the Aboriginal participants in this study. One participant explained “I can’t do everything. If I think I can do everything then I actually am not a good leader. It’s coming back to the grassroots stuff... It’s coming from a strength based [approach]”. Another participant stated “there’s no way I could do this on my own, what I do. I think it’s a team. My staff, my team, everyone, we all share the same vision here… so they guide me as much as I guide them with our everyday work that we do with Closing the Gap”. On reflection, one participant described this collective leadership style as an element of Aboriginal culture. They said that this type of leadership reflects “our inner circle and the rest of it comes out of that. Our elders will give us information and take us on a journey. We are the next elders… That’s how I see what good leadership is”.

This model for leadership was demonstrated through Rumbalara by Aboriginal women. On one visit to Shepparton, I learned of an initiative where the local Aboriginal women were reaching out to other minority groups. The women explained they had facilitated an event with the local Turkish women to share stories of life in Shepparton and to seek support from one another. When I talked with the Aboriginal women they had just come from the women's event and were buzzing with energy. They shared that one of the Turkish women had reflected that even after 40 years in Australia, no one had ever welcomed her to country before and this gave her an importance sense of belonging and acceptance. The leadership shown by the women from Rumbalara to connect with others in the wider community reflects social determinants of Indigenous health and is consistent with the collective style of leadership described by participants in interviews.

Participants identified that one way for leaders to promote self-determination was through advocacy to influence policy implementation. They described "champions [who] provide an avenue for us to have a voice". One participant explained "you've got to have a big voice, you've got to be confident to voice your opinions, to make informed [decisions] and to stand up for what you believe in". One example of the influence of champions was discussed by participants in a follow-up workshop. They identified that in the past, the media had portrayed the local Aboriginal community negatively, focusing on problems, and framing Aboriginal people with a deficit lens. Participants explained that in response, Aboriginal leaders built relationships with people in media. They started to write their own stories that were positive and reflected strengths of the community. "We took it into our own hands and put our own stamp on the news. We counteracted their negatively with our positivity. Everything we did that was positive, we put it in the local news. We started to control the narrative". This shift in reframing the discourse was seen by Aboriginal participants as a significant act of leadership, consistent with self-determination.

Prominent Aboriginal Elders or "champions" have been immortalised in the city of Shepparton in murals. The first nine meter high mural features Yorta Yorta men Pastor Sir Douglas Nicholls and William Cooper and was launched at the 50-year anniversary of the 1967 referendum to recognise Aboriginal and Torres Strait Islander people as citizens of Australia (Staynor, 2017). The men depicted in the mural fought for Indigenous rights and reconciliation. A second mural of two Aboriginal women, Aunty Margaret Tucker and Nora "Nanny" Charles was launched in 2018 (Greater Shepparton City Council, 2018). A third mural was completed in 2020 to honour

Aunty Geraldine Briggs and Aunty Elizabeth Morgan (Mellino, 2020). When I stood beneath murals it was impossible for me to ignore the legacy of activism and the fight for Indigenous rights (Figure 10). These “champions” paved the way for generations to continue the fight for self-determination and the celebration of this artwork acknowledged their contribution to recognising Indigenous rights in the region.

Figure 10: Photos of the Aboriginal Street Art Project in Shepparton, May 2019 (Photos by Emma George)

Another example of advocacy and leadership that participants pointed to, was the Rumbalara discussion paper on changing the paradigm to ‘close the gap’ (Rumbalara Aboriginal Coorperative, 2016b). Aboriginal participants referred to this document agreed that “normalised unwellness” was an issue for the local community. One participant explained that Aboriginal people in Shepparton would “only go and see a doctor when you’re really, really sick, but you’re feeling crap all the time; you normalise it, you don’t get it fixed”. Another participant explained “certain people will accept a certain level of violence but then it if goes above [that accepted level] then they’ll seek help, but they accept A, B and C, but won’t accept D or E”. Following on from this, another participant clarified that even after Aboriginal people in the community seek support or health care, “we’re only getting back to a certain level where we can function so [there’s still] pain in the gut, or levels of diabetes, they’ll only manage just so they can still function and they think that’s good health. There’s a different level of understanding or acceptance of what good health is, and what we’re actually accepting and living with”. The participants’ depth of understanding of “normalised unwellness” demonstrates support for Rumbalara’s research and is evidence of the capacity of community-led services to understand health needs and issues. Participants called on the research as they answered questions about leadership, advocacy and “champions”. While participants agreed with the findings of this discussion paper, they were unsure how the publication of the research results would influence policy, even though the findings highlighted significant gaps between the targets of the CTG strategies and the needs of children, families and communities at the local level. One of these gaps highlighted by participants is the lack of recognition of rights for Aboriginal children and therefore social determinants of Indigenous health in early childhood were not seen to be prioritised within the CTG strategy.

5.2.7 The right to an Aboriginal childhood

Participants were asked for their thoughts on rights within the CTG strategy and in particular, what they thought about rights for Aboriginal children. Participants explained that children exist within families, and therefore children have a right to a holistic, family and community approach to early childhood. One participant simply explained, “to have a good childhood, you need healthy parents”. Another participant recognised that the family and community collective nature of parenting was important for raising Aboriginal children. They explained “You know, we do it in a different way. Our mothering’s different. Our parenting is different. Our families are different. I look at when my son [is] starting school next year, I’ll probably have about 40 people up there to see him at his first day of school because that’s our family. Like it’s not just mum, dad, siblings, it’s aunties, uncles, cousins.” For this participant, healthy early childhood includes family and community. Participants advocated for a healthy Aboriginal childhood to also include rights to social determinants of Indigenous health. There was overwhelming support from all participants that “Aboriginal children should have a right to an Aboriginal childhood”. When asked about this idea, participants explained that an Aboriginal childhood should include culture, connection, being on country, and spirit. For example, one participant explained that an Aboriginal childhood reflects “who we are, that’s our culture, our making and our beliefs, it’s connection”. Another participant said “If we want our kids to feel good about themselves and to be able to be learners, then they have to be an Aboriginal child. That’s a given.” Even though rights to an Aboriginal childhood are not specifically outlined in policy, they are reflected in policy implementation in Shepparton under the influence of key policy actors, leaders and champions. For example, “Bush kinder allows the kids to not only learn but they’re learning about culture they’re learning about country, they’re interacting with, you know, kids of their own background, those sorts of things as well. It gives them the right, I guess, to learn about their culture in a safe environment.” This type of early childhood education experience where children can learn Aboriginal ways of knowing, being and doing, was seen as important because it is an “opportunity for [children] to go on country, on other people’s country, and in that strengthen who they are and their own identities”. As one participant explained, “I think it’s essential to keep our culture alive. It’s essential for the kids to learn those things, to be a part of it.”

While participants agreed that Aboriginal children have a right to an Aboriginal childhood, they reported that they did not think this was a priority within the CTG strategy itself. Participants recognised that “mainstream kinder is a fairly structured environment” and that historically, people have not always had opportunities for “cultural upbringings… [even though] every kid should have the chance to have that as part of their life”. One participant explained “all of the young people that I have worked with in my life where they haven’t had that ability to connect with family, connect with culture, country… they are so lost”. One participant explained that this is complicated by the high “number of vulnerable families and children who don’t have any sense of their heritage… either there’s no generation to tell them, or there’s been removals, or the children have been in the system long term and were never [told of] their heritage”. The Aboriginal-led early childhood programs in Shepparton provide services to support children and families to learn more about their culture and identity, even when they do not receive direct CTG funding. One service was described as “a place of connection [for] our kids, especially our [out of home] care kids. You know some of them come here and don’t have an identity”. As a result, participants reported stories of positive reengagement in culture through a strong sense of belonging and safety. One participant said:

> “a [government department] worker only just two weeks ago rang me to check up on one of the little boys that’s just started here and she said – “I’m about to fall off my seat with the report that you’ve just told me’ because I said ‘he’s perfect. It’s like he’s been here forever” – and she said the other kinder wanted to ban him from coming because of his behaviour. I said it’s probably because he feels culturally safe and talking to his carer, he goes home every night saying he loves his aunties”.

This same service provides a place for families divided by the removal of children who are at risk, to reconnect with one another. One example given by a participant told a story of a family with 5 children separated into 3 homes but “here was a place of them to have that connection… The older siblings would come after school and play with them and see them, [this] was a key place to keep that family together and feel connected… so I bring that up a lot in the Department to say, we can provide that sibling contact if you're going to break up the family connection." These comments highlight participants' understanding of gaps related to social determinants of Indigenous health which are not included as targets within the CTG strategy. The examples of actions that promote rights to an Aboriginal childhood reinforce the influence participants in this study have had over policy implementation.

5.3 Chapter Summary

Findings from the Shepparton case study revealed that community-controlled services in health and education provide essential services to the Aboriginal community but that Rumbalara in particular is much more than just a service provider, it is also a place that provides belonging, culture and strength to children, families and communities. Policy implementation is complicated by the constraints of a complex funding and reporting models and the challenges of partnerships across services and sectors. Despite the challenges, participants acknowledged ways in which they influence policy implementation to in response to local needs, and promote social determinants of Indigenous children's health. Participants identified a link between leadership and self-determination and that the fight for Indigenous rights draws strength from the resilience of previous generations, and is ongoing. Finally, participants agreed that Aboriginal children have a right to an Aboriginal childhood which reflects culture, connection, being on country, and spirit.

CHAPTER 6: SOUTHERN ADELAIDE CASE STUDY

In this Chapter I report on findings from the Southern Adelaide case study. The results are drawn from my experience living in the region and interviews with participants in government and non-government sectors in health and education. Nine participants identified as Aboriginal and Torres Strait Islander and seven were non-Indigenous. Consistent with the previous chapter, in order to protect the anonymity of participants, quotes are not linked to any identifying feature other than Aboriginality when necessary.

I begin with an overview of the Southern Adelaide context including the Kaurna people and the Tjilbruke dreaming story. Following this I provide an overview of the Southern Adelaide health and education services who have had a role in implementing Closing the Gap (CTG) policy in early childhood. Then I draw on the themes that emerged from analysis of the interview data in Southern Adelaide, and discuss participants understanding of CTG policy implementation.

6.1 Southern Adelaide History and Context

Southern Adelaide as a region comprises a number of local government areas. This region is the traditional land of the Kaurna people, locally referred to by Aboriginal people as “Nunga”. The state of South Australia was established as a British colony in 1836 and by the mid-1800s, Kaurna people were driven off their land into mission stations outside of the region and they were forbidden to speak Kaurna language (The University of Adelaide, 2019). The loss of linguistic heritage for Kaurna people, and other South Australian Aboriginal people has been attributed to population loss following disease, theft, violence, and colonial and assimilationist policies (Amery, 2015, 2019). Kaurna elders Dr Kauwanu Lewis Yerloburka O’Brien and Dr Alitya Wallara Rigney worked for many years and helped to establish ‘Kaurna Warra Pintyanti’ to bring together Kaurna people, teachers, linguists and allies to reclaim and promote the Kaurna language (The University of Adelaide, 2019). The revitalisation of the Kaurna language has served to enhance connection among Kaurna people as they still navigate pressure to conform to mainstream society while at the same time embracing and understanding cultural heritage and identity (Amery, 2019).

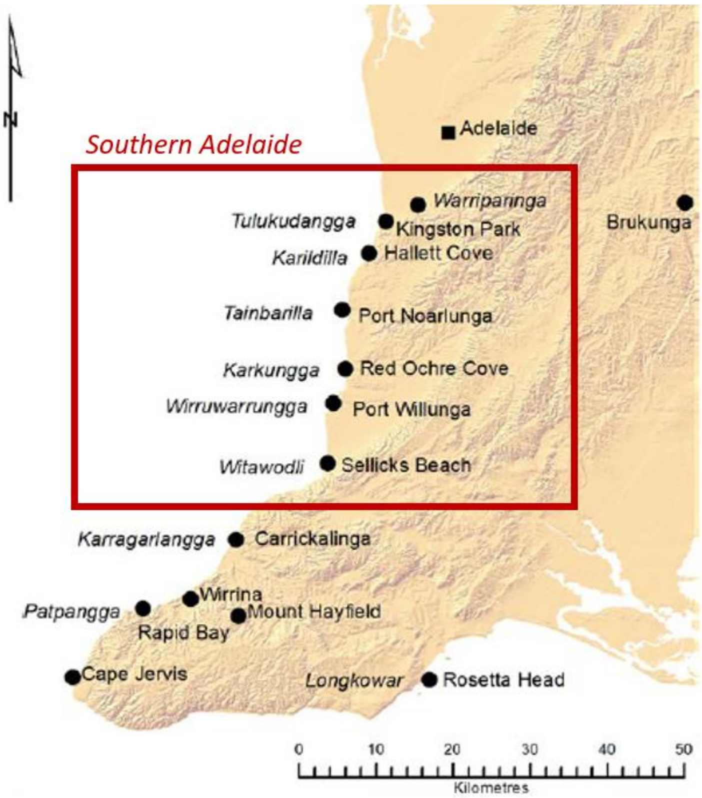
6.1.1 Tjilbruke Dreaming

The story of Tjilbruke is an important part of Kaurna history and belonging (Malone, 2012). The best known aspect of the Tjilbruke story is the creation of fresh water springs along the Southern Adelaide coast. A short version of this complex and multi-layered story is published by the local council:

> “Tjilbruki was an ancestral being of the Kaurna people of the Adelaide plains, whose lands extended from Parewarangk (Cape Jervis) in the south to Crystal Brook in the north. Tjilbruki's much loved nangari (nephew) Kulultuwi, his sister's son, killed a kari (emu) which was rightfully Tjilbruki's but he forgave him for this mistake. However, Kulultuwi was subsequently killed by his two-part brothers, Jurawi and Tetjawi supposedly for breaking the law.
>
> Tjilbruki, being a man of the law, had to decide if Kulultuwi had been lawfully killed. He determined Kulultuwi had been murdered. Tjilbruki avenged the crime by spearing and burning the two nephews, killing them. This happened in the vicinity of what is now called Warriparinga.
>
> Tjilbruki then carried Kulultuwi's partly smoked dried body to Tulukudank (a fresh water spring at Kingston Park) to complete the smoking and then to Patparno (Rapid Bay) for burial in a perki (cave). Along his journey he stopped to rest and overwhelmed by sadness, he wept and his luki (tears) formed the freshwater springs along the coast at Ka'reildun (Hallett Cove), Tainba'rang (Port Noarlunga), Potartang (Red Ochre Cove), Ruwarung (Port Willunga), Witawali (Sellicks Beach), and Kongaratinga (near Wirrina Cove).
>
> Saddened by these events Tjilbruki decided he no longer wished to live as a man. His spirit became a bird, the Tjilbruki (Glossy Ibis), and his body became a martowalan (memorial) in the form of the baruke (iron pyrites) outcrop at Barrukungga, the place of hidden fire (Brukunga - north of Nairne in the Adelaide Hills). Tjilbruki was a master at fire-making”.
>
> (City of Marion, n.d.)

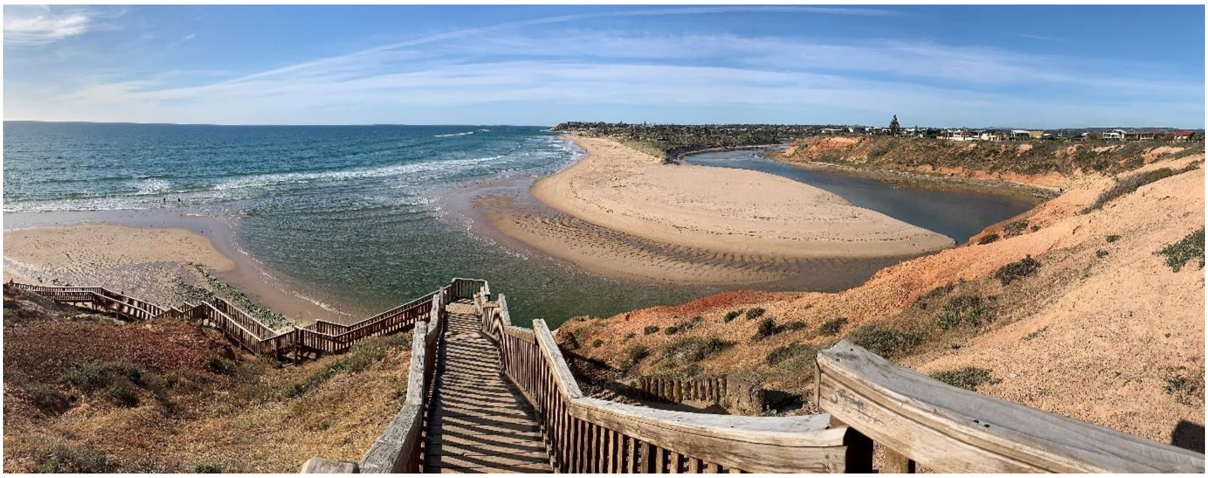
Many of the sites mentioned in the story are located within the Southern Adelaide case study for this research as shown in the annotated Figure 11, originally published by Malone (2012).

Figure 11: Sites from the Tjilbruke story, adapted from Malone (2012, p. 211)



Warriparinga is home to the Living Kaurna Cultural Centre and artwork representing the Tjilburke Gateway, developed by the local council and the Kaurna community, acknowledging Warriparinga as a site of significant cultural heritage (City of Marion, n.d.). Just south of Port Noarlunga is the mouth of the Onkaparinga River, as shown in Figure 12, known as Ngangkiparri in Karuna language. This is just one of the beautiful natural features of the Southern Adelaide region.

Figure 12: Mouth of the Onkaparinga River, Ngangkiparri, Southern Adelaide case study (Photo by Emma George)



6.1.2 Services in Southern Adelaide

The Southern Adelaide Local Health Network (SALHN) provide health services across the region, including the Flinders Medical Centre, Repatriation General Hospital, Noarlunga Hospital, GP Plus Health Care Centres and Super Clinics, and sub-acute and mental health services (SA Health, 2012b). Aboriginal specific health clinics operate at two sites in the Southern Adelaide region (Noarlunga and Clovelly Park) and they exist to actively support Aboriginal people improving their health and well-being through culturally appropriate services that are responsive the needs of the southern community (SA Health, 2012a). The closest Aboriginal Community Controlled Health Organisation is Nunkawarrin Yunti, located in the city centre but there are no services in early childhood provided by Nunkawarrin Yunti in the Southern Adelaide region.

6.1.2.1 Taikurrendi Children and Family Centre

The Taikurrendi Children and Family Centre (Taikurrendi) was established under the CTG National Partnership Agreement on Indigenous Early Childhood Development. Taikurrendi's vision is to be,

> "a safe place for every child and family, where culture will develop and thrive. Partnerships and ongoing relationships are fostered to support opportunities for children, family and the community engaging and learning through education. We will always aspire to reflect a socially just environment that champions the rights of all children and values the identity of our community" (Taikurrendi Children and Family Centre, 2015, p. 1).

The centre is embedded within the state education department and therefore sits within a mainstream model of policy implementation. As a mainstream children's centre, it is open to all members of the community for preschool, occupational care, Learning Together programs, playgrounds and additional parenting support and health services. Taikurrendi describe themselves as having a "strong focus on supporting Aboriginal families with young children and reflects a philosophy of acknowledgement, engagement and inclusion of Aboriginal history, culture and community" (Taikurrendi Children and Family Centre, 2017, p. 1). In the Australian government's evaluation of the national partnership agreement, Taikurrendi is described as "an example of a consultation process that was collaborative, and created opportunities for community members" (Thomas, 2014, p. 103), with specific praise given to targeted programs for Aboriginal and Torres Strait Islander children offered through the centre. Overall attendance at the centre in the kindergarten program has increased from 41 children at the start of 2015 to

60 by the end of 2017, with attendance consistently over 80%. The number of Aboriginal children included in these statistics is unknown. When I first visited Taikurrendi in 2016 there were very few Aboriginal people at the centre however over time, I have observed increasing community engagement through the services offered and the number of agencies who utilise Taikurrendi as a meeting place. One of the local Elders weaving groups have met at Taikurrendi and community members explained to me that this sends a message to the wider community that Taikurrendi is a safe place for them. The centre itself is still very new and therefore the facility has a modern design with a foyer, office space, community meeting spaces, and the kindergarten and playground. The Aboriginal and Torres Strait Islander flags are flown as shown Figure 13, although these flags are difficult to see when you access the site from the carpark.

Figure 13: Taikurrendi Children and Family Centre, Southern Adelaide case study

Image removed from thesis. See photo at link:
https://www.preschools.sa.gov.au/taikurrendi-children-and-family-cent/our-centre/reports-and-plans

6.1.2.2 Christie Downs Kindergarten

The Christie Downs Kindergarten is located less than two kilometres from Taikurrendi. Christie Downs Kindergarten is also embedded within the state education department and has supported Aboriginal families for multiple generations. They have similar enrolment numbers to Taikurrendi with 51 children enrolled at the end of 2018 (Christie Downs Kindergarten, 2019a) and one participant in this study estimated that approximately 80% of the children would identify as Aboriginal. The philosophy of Christie Downs Kindergarten is that,

> “every child is special with a connection to land and community. Spiritual growth and valuing the individuality of each child’s diversity of cultural background is nurtured. Our play-based learning program supports the children’s desire to come to kindy and enthusiasm to learn and gain successful outcomes. Relationships with children and their parents are paramount along with a safe and welcoming environment, which are crucial in supporting wellbeing along with the happiness and joy gained from the wonder experienced in early childhood and our learning program. Staff strongly advocate for the inclusion of our Aboriginal children and parents into the wider community in a variety of creative and positive ways. Staff are connected, resourceful and committed to the environment within the kindy and wider community, which also supports our holistic and flexible service delivery program to engage with the community and bond with children” (Christie Downs Kindergarten, 2019b, p. 3).

One of the strategies to promote engagement among Aboriginal families is the provision of a 22-seater bus to pick up Aboriginal children from surrounding districts who "want their children to be enrolled at a site which will support their cultural identity through the employment of Aboriginal staff and a program which is inclusive of their needs. Some families and children are isolated and disengaged and this needs to be acknowledged" (Christie Downs Kindergarten, 2016). On visiting the Christie Downs Kindergarten, I noted the dated style of the building with one large room for children with the attached playground. The space is open and inviting to visitors. Christie Downs kindergarten is easily identified as a place that welcomes Aboriginal families with the position of the Aboriginal flag on site and on the side of the bus, as shown in Figure 14 from the kindergarten's website.

Figure 14: Christie Downs Kindergarten (n.d.), Southern Adelaide case study

Image removed from thesis. See photos at links:

https://www.preschools.sa.gov.au/christie-downs-kindergarten/our-centre/things-to-know

https://www.preschools.sa.gov.au/christie-downs-kindergarten/our-centre/reports-and-plans#nqschristiedowns

6.2 Southern Adelaide Case Study Results

Seven key themes emerged from the data following interviews with participants:

1. The rapid introduction of the CTG strategy
2. The impact of short-term funding
3. Cuts to Aboriginal health services
4. Experiences of consultation
5. Implications of a mainstream model for policy implementation
6. Understanding power in policy implementation
7. Understanding Aboriginal childhood in Southern Adelaide
8. A vision for policy implementation

6.2.1 The rapid introduction of the CTG strategy

The first iteration of CTG strategy in Southern Adelaide brought “unprecedented funding into Aboriginal health space”. Despite the initial optimism about new opportunities that the CTG strategy offered, Aboriginal participants agreed that “it was flawed from the get go,” because of a sudden influx of funding and rushed implementation process. One participant explained “with a rapid process you actually leave out key processes, key people, key structures. In order to get something out quickly, those things suffer.” Another non-Indigenous participant expressed concern over such a rapid roll out and said “the money came in a bit like a freight train and we had to, literally in a week’s time, something really ridiculous, one or two weeks, we had to come up with a comprehensive state plan.” This was confirmed by another Aboriginal participant who explained that the CTG strategy “just got chucked out there really quickly because you need to start spending it or you’ll lose it.” On reflection, on participant suggested that “what really ended up happening was that people were putting in their pet projects as opposed to a strategic approach” and they went on to explain that what was missing was an opportunity to “take stock of what our data and our [evidence] is telling us about Aboriginal health” which would have led to implementation in “areas of greatest need for the greatest impact”. Ultimately, all participants agreed that the rapid roll out CTG policy occurred without clear direction from the commonwealth or state government.

6.2.2 The impact of short-term funding

As a result of the “rapid roll out, funding to organisations through CTG was short-term which seemed to “really put Aboriginal led organisations on the back foot”. This short-term funding was described as “unhelpful” because even when outcomes are achieved, funding is often pulled from projects. One participant clarified that short-term funding agreements within CTG policy also had a lot of criteria, limiting flexibility in implementation. The result in early childhood was that positive outcomes didn’t always perfectly fit the criteria. For example, programs funded through CTG to support families in crisis would take time to see improvement in child health. Even when outcomes were directly working towards closing the gap in health inequity, successful projects were at risk of being defunded. This was described as trying to fit “circles into square holes”. An Aboriginal participant explained “all we’re doing now is going year to year and that’s not commitment, that’s just ad hoc funding and that stop-start thing, which does not work for our Aboriginal communities.” In addition, participants agreed that it was difficult to obtain long-term support for closing the gap initiatives because “it’s hard to make a case [for Aboriginal health] when outcomes are very long-term, beyond everyone’s contract, you know, beyond an electoral cycle”. As a result, one participant explained “we’ve got all these documents there and they’re very nicely presented but there’s no teeth… there’s no action. All talk and no action”. Participants explained that the lack of long-term support through CTG was not only seen in early childhood but across other sectors as well. Participants recognised that children exist within family and community structures and therefore policies outside of the early childhood sector, still impact on the health and well-being of children.

6.2.3 Cuts to Aboriginal health services

At the same time as the rapid roll out of the CTG strategy, significant cuts to government Aboriginal health services were enforced. Within the state health department, the “Aboriginal health branch used to have 30 people in it; now it’s got five”. Participants reflected on the cyclical nature of policy in Aboriginal health with repetition of a cycle of programs being established and cut, established and cut. One participant explained “they’ll cut, then they’ll set up an Aboriginal unit with resources because it’s the flavour of the month… you go on and thing start to roll, you’ll get some consistency and then the next government will come in, and you’ll roll back again”. They went on to say “they’ll cut and it’ll look completely differently to how it was – even if there’s evidence to say things are working, still things get cut”. The significant cuts to Aboriginal health resulted in structural distance between local health services and health department leadership. One participant explained,

> “when I had a look at the restructured organisational chart it was [the Minister] at the top and Aboriginal health did not have a direct line of reporting anymore; they were about fifteenth on the ladder… second from bottom, and with no opportunity to speak… It was this convoluted and complex reporting process up to that level… the distance was significantly increased for Aboriginal people’s voices to be heard”.

All participants supported the “need for Aboriginal leadership throughout the policy process.” There was consistent promotion for “Aboriginal people writing, if not co-designing policy… We can’t be everywhere… but we can be concentrated on our Aboriginal business”. One participant stated that “the executive [in the government Department] have no experience working with Aboriginal people and they’re not very up to date at all with Aboriginal health.”

Aboriginal participants expressed their pain throughout policy implementation that results in such significant cuts to Aboriginal health. They argued:

> “we would have worked out a way to actually get collaborative support from key parts of the department to ensure that we had capacity to maintain [structures and services]… and then [the restructure] became terrible… I said I don’t understand where you’re coming from because what that shows is you’re actually ignorant… you don’t do things for us without us… I never felt so marginalised… They saw us as being disgruntled, unhappy”.

A non-Indigenous participant also acknowledged the pain caused by significant cuts to Aboriginal health services. They explained “that’s the heartache of it all… Once the funding ceased, numerous Aboriginal people lost their positions, programs no longer existed… Aboriginal people either became sicker, services closed down or [programs] went to mainstream services which are culturally unsafe”. On the other side of the story, policy actors explained some of the cuts were a result of a lack of reporting where “on paper, [some programs] looked so bad that we could not possibly justify putting them forward”. This was “not necessarily because the people on the ground may have done a poor job, they just didn’t give us ammunition to fight with”. They clarified that the lack of evidence to support programs was not a result of poor services or an inability to complete the work, rather the lack of reporting was due to excessing administrative demands putting excess stress on services. This participant went on to explain that “outcomes are so far ahead that sometimes, we have to just demonstrate that we’re doing something for our money... You have to just show that you’re running a good business, in a sense because otherwise there’s nothing I can do”. This reveals a distance between government bureaucrats responsible for making policy decisions and the health and education services, resulting in structural issues that impacted on the implementation of the CTG strategy in early childhood.

Cuts to Aboriginal specific programs were also experienced in Southern Adelaide following the roll out of the Indigenous Advancement Strategy (IAS) as part of the second iteration of CTG policy under a national Coalition government, post-2013. Many participants expressed frustration that the Aboriginal Family Support Service (AFFS) had to leave the Southern Adelaide region due to funding restrictions. AFFS is an Aboriginal controlled organisation working to redress injustices and provide support, assistance and advocacy to Aboriginal children and families REF. AFFS reported that the funding cuts under the IAS resulted in closing the community wellbeing program at Christies Beach (and a service in the north of Adelaide) in April 2015 (Aboriginal Family Support Services, 2015). Participants explained that this left a hole in service provision but the impact was felt widely across the community as the defunding of this visible and well-known service, implied that the IAS was not really in support of Aboriginal children and families.

6.2.4 Experiences of Consultation

Following on from the rapid roll out of the first iteration of the CTG strategy, participants described their experiences of consultation both as policy actors engaged in implementation, and as members of the Southern Adelaide community. Participants expressed frustration with the process of how consultation was delivered, as well as the underlying assumptions or intentions. The inflexible process of consultation was reflected in the “nine to five” nature of the work which limits community engagement. One participant explained “they want the voice of Aboriginal people who don’t work. They want unemployed Aboriginal people to make decisions on everybody because all consultations are nine to five”. Another participant stated that even when the broader community are able to participate in consultation, it is “a bit like paying lip service and it’s like ‘we’ve heard you and so we’ve done consultation’.” They went on to explain that when community participate in consultation, they expect action or change in response to their voice. However, in Southern Adelaide the community consensus was that the government would push ahead with their own plan regardless of the information from consultations. The same participant said, “the bureaucracy just whitewash it and go ‘no, we’re going to do this anyway, but we did listen to them’.”

These experiences of consultation were described as “tokenistic”. Two participants referred to consultation as a “tick the box” activity of policy implementation. A non-Indigenous participant said “for me it was a tokenistic approach, getting an Aboriginal person to sit at the table, ‘yep, we’ve ticked that box’ and the biggest anxiety for me was the lack of Aboriginal consultation in that process, the lack of community people that were brought to the table to truly say ‘this is what we need for the south.” An Aboriginal participant supported this idea when they explained “it does seem like a tick box thing, like we talked to the community and so we’re done with consultation and that seems to be what consultation is now.” Participants agreed that a more accurate definition of their experience of consultation in CTG policy implementation is “information sharing.” Participants suggested that the tokenistic nature of consultation was reinforced when community was informed of policy implementation rather than implementation occurring in response to community. For example, “they ask us about things which they’ve already decided what they’re going to do, so it’s kind of like you’re consulting but you’re not, because you’re going to go ahead to do what you’re going to do anyway, even if we give you a different viewpoint.” Half of the participants in Southern Adelaide described governments as “not really listening” during consultation. As one participant put it, “governments aren’t particularly good listeners.”

One of the barriers identified by participants is the lack of conversation with community about the causes of health inequity, particularly “dispossession and oppression and what’s happened to Aboriginal people in this country… they don’t too much about that”. Participants suggested that really getting to root causes of health inequities requires more than “sitting around a big table” and that governments have a responsibility to “speak to the people, come down from your ivory [tower] and get out in communities. Actually listen with your ears and eyes and heart and your minds and your soul.” Another participant described this as “proper listening to what people say and then do something with it.” One Aboriginal participant described a “very white centric” approach to consultation which limits the influence or presence of Indigenous knowledge in policy implementation. They explained “they’re not considering Aboriginal knowledges and ways of being, knowing and doing which can actually be effective in helping Aboriginal people… top down approaches crush this knowledge”.

The experience of consultation in Southern Adelaide was particularly difficult for the Aboriginal participants who helped to facilitate consultation. These participants were aware of the tokenistic and limited nature of the process and lack of flexibility for outcomes. One participant explained “as Aboriginal workers when we go out and consult, that’s hard for us because when we bring it back we know that our sphere of influence is only so big, and what you can change is so limited”. Another participant said that facilitating consultation makes them vulnerable to racism from the broader community and that “the stuff you hear, I used to come out of there with a headache, actually feeling like I want to vomit, just sitting there talking to people and you’re so offended, disgusted.” These participants described the weight of expectation to be an advocate for the Aboriginal community, but when “they’re giving their voice and they’re telling you [what they need] but then they don’t’ see it change”, it can be a very difficult responsibility.

Participants recognised the tokenistic and frustrating experiences of consultation in Southern Adelaide led to community conflict, particularly with regard to the process of establishing Taikurrendi. On one hand, participants felt that they knew Taikurrendi was always going to be embedded with a government department and therefore located at the site of the local primary school. This was described as a “non-negotiable”. Other participants felt that that this was never clearly outlined and therefore they felt cheated that Taikurrendi never really belonged to the community. Participants described the disappointment felt by community because “when it comes to the crunch, the support [from government] isn’t actually there”. One participant explained that the community lack of awareness of the “non-negotiables” meant that it was impossible for community to feel part of the process and have ownership. As a result, “people are holding on to those expectations” and then community feel let down by workers who they trusted. One participant suggested that “there was never, ever a thought of [Taikurrendi] being an Aboriginal kindy even though it was [established] with Aboriginal money… The spirit of the agreement was about health and education coming together to have the best outcomes for Aboriginal kids. It’s a state kindy”. Another participant explained “it’s more mainstream that it is Aboriginal”. A third participant agreed with this sentiment and explained “I think the initial concept of Taikurrendi [as an Aboriginal children’s centre] was pretty special and we missed that opportunity”.

The other side of the story is that the “non-negotiables [for establishing Taikurrendi] were always there”, and the result of embedding the centre within a government department is a financially sustainable children’s centre with an Aboriginal focus. This sustainability is a very different experience to the cuts seen in the Aboriginal health sector. One participant explained that consultation on Taikurrendi was "not just a bit of hit and miss, it was really well thought out, authentic, progressive, a slow walk to what we thought would be best for community… in terms of maximising outcomes for all our kids but particularly our Aboriginal and Torres Strait Islander kids at the end of the day". They clarified that community assumptions that Taikurrendi would be just for Aboriginal and Torres Strait Islander children and community was a "misconception", which in hindsight, meant that from the outset, consultation was always going to appear tokenistic. These assumptions, misconceptions, unmet expectations, and frustration led to conflict within the community and resulted in some Aboriginal families avoiding the centre, while others took "a couple of years" to begin to feel comfortable visiting the site. On reflection, one non-Indigenous participant stated "there may have been some of the Aboriginal and Torres Strait Islander community that did not want to engage because perhaps that wasn't what they felt would serve their needs most, or what they believed the community needed… that certainly wasn't intentional, but I think in whole communities we have to understand there's lots of different thoughts and views". These results are suggestive of inadequate consultation processes that contributed to conflict within the community, adding to a psychological toll of feeling unheard during policy implementation.

6.2.4 Implications of a mainstream model for policy implementation

Participants explained that across education and health services in Southern Adelaide, services for Aboriginal people were "absorbed" within the "mainstream". Services such as the Aboriginal health clinic are targeted specifically for Aboriginal families and Taikurrendi is a universal access service for all the community. All participants agreed that policy implementation that specifically endorsed Aboriginal services within the mainstream should support social determinants of Indigenous health, including a "recognition and connection to country, land, and the history and impact of colonisation on emotional and social well-being". However, "if there is not that understanding, there can be misunderstanding, miscommunication and possible disconnect" where policy is imposed on to a community, "rather than being from the community up". For example, one participant explained that the health service "just doesn't feel like it's an Aboriginal health clinic, it just feels like a mainstream health service – the Nunga staff are there, but not always – my experience going in and out is a bit like it could be any other service". Participants expressed disappointment with services being embedded with the mainstream. One participant explained "you see things get cut and the next thing you know, they're given to a mainstream service with no Aboriginal faces in there, no Aboriginal knowledge in there… You can't do that without Aboriginal staff. You can't do that without Aboriginal leadership, Aboriginal advice… it'll just go backwards". Another participant questioned "what's the point of cutting back and mainstreaming everything if you're supposed to be closing the gap? To me their interpretation of closing the gap is mainstreaming it".

Participants also identified limitations with a model of service provision with universal access even though "universal access is theoretically flawless" because services should be accessible for all people. However universal access is not always culturally accessible because "for Aboriginal people, wherever they go, they don't feel like it is for them. Another participant explained that "the push to try and get people out into the mainstream is all well and good if that worked for everybody… [but] one size doesn't fit all". One participant compared universal access to cultural blindness and suggested that a common argument supporting universal access is that "we should treat everyone the same because other cultures are suffering too". They went on to explain that there is a responsibility that policy should be implemented to address the health inequities experienced by Aboriginal people who have the worst health outcomes. "There is a responsibility to fix the system that broke people".

Aboriginal participants linked the mainstreaming of services to the lack of progress in closing the gap in health inequity. One participant argued "there's no closure in the gap and I'm very vocal, respectfully when people talk to me about that and I respond that I can't see any gaps being closed, I really can't… because when you look it from how we are, an Aboriginal [targeted] service in the mainstream, there are policies and procedures that restrict us to a certain extent". Another participant explained that because of the way they were directed to implement policy, services were unable to respond flexibly to local community. They stated "what would work for Southern Adelaide, what would work for northern Adelaide, it's different and the needs are different, and the communities are different… We threw all this money at [the gap] and it hasn't gone away". Another participant explained that mainstreaming "doesn't work because the leadership are non-Aboriginal. They see things through their eyes, in their image. If they don't consult, if they don't take note of how it is for Aboriginal people, they will miss the mark, like they have been doing for many, many years". Here, findings from this study affirm my analysis of policy documents; that a mainstreaming approach is likely to serve as a barrier to recognition of social determinants of Indigenous health and Indigenous rights.

6.2.4.1 Influence of non-Indigenous Non-Government Organisations (NGOs)

A concern raised by most of the Aboriginal participants was the influence of non-Indigenous service providers, particularly NGOs accessing funds designated for closing the gap in Indigenous health inequity. The issue is a perceived lack of transparency or commitment to cultural safety. One participant argued that “it’s simply a money thing and people are putting their hands up for it and saying ‘hey, we want a piece of that pie’ [but] should you be putting your hand up for it? I don’t think many of them have a way of incorporating [Indigenous] knowledges so then we are just harking back to the humanitarian goodwill of the missionary days”. Other participants were suspicious that non-Indigenous organisations who had accessed CTG funding had not been required to evaluate their outcomes. One participant explained “I can tell you now none of us can access government money without having to justify to the tee why we need that money. I’m hearing that there’s non-Aboriginal organisations accessing that money that don’t have to provide an evaluation report”. One participant expressed anger about this because it is the opposite experience of Aboriginal workers who “have to justify a dollar for your program every time you need a dollar – is absolutely crazy and I think that level of vulnerability, can only really be felt and understood by another Aboriginal person”. Another participant suggested that non-Indigenous organisations invite a “consultant” to come in and write grant proposals but then “there’s been so many cases where non-Aboriginal NGOs have got the funding and then they just go about their business and they don’t employ Aboriginal people and they don’t reach their targets because they’ve got nobody in their governance that is Aboriginal that can actually provide them with good knowledge to do their business”.

Participants reflected on the lack of transparency in policy implementation leading to a lack of trust. One non-Indigenous participant recognised that “having conversations around Aboriginal health and Aboriginal well-being is really important with the key people you work with because then you know where they are coming from… but in the first instance, you don’t trust”. One Aboriginal participant revealed their lack of trust in reporting on policy implementation and explained “in the reporting mechanisms that they sent out to me, it does not say “Aboriginal children”, people will write 20 children attended but nobody will run up and ask were they all Aboriginal?” The lack of detail in the reporting meant that they could not trust policy evaluation.

In addition, Aboriginal participants explained that the lack of trust filters down to the community level. For example, “an Aboriginal person walking into a white organisation asking for help takes us right back to the ration line. It puts us back in that position and the non-Aboriginal people don’t notice that and don’t understand that because it’s not something they live… then families get denied help because people behind the desk can’t relate to them, can’t understand them and they are frightened for their safety. They [the service providers] just want these fellas out of their face and away from them because they can’t handle what’s happening in front of them”. On the other hand, one participant explained that “visibility” of Aboriginal culture and understanding is essential. They maintained that when Aboriginal staff and culture are present, community are more likely to engage in services. For example, “the fact that when you walk through the gates you start being presented with Aboriginal design you start seeing an Aboriginal presence in a place. You go “this is me”.

6.2.4.2 Experiences of racism and the lack of cultural safety in policy implementation

Both Aboriginal and non-Indigenous participants highlighted that “mainstream services are culturally unsafe and [community] don’t feel as if they are being heard or understood. They are confronted with racism and discrimination every day. It’s just so much part of their lives that it makes them sick”. An Aboriginal participant argued that racism “is felt every day by Aboriginal people across the country. The judgement, the racism, the stereotypes”. The outcome of “culturally in-competency” is that Aboriginal people “just don’t go”. For example, one participant shared an experience of a client who reported “I didn’t like the way the midwife spoke to me. I’m not going to [name of service] because the last time I went there they did this to me”. Not only was this described as a challenge for community who receive health services, but participant described the secondary impact of racism on workers who implement policies. This same participant felt discouraged and overwhelmed by the “countless time” clients were faced with unsafe practices and they explained with tears in their eyes, “there’s nothing we can do about it except encourage the client to make a complaint, fill out of form, which they don’t do, and they never do”. In response to these experiences of racism, Aboriginal participants reported that they had approached health sector leadership to try and explain “when I see things, you don’t see them the same as me” and then they encouraged their non-Aboriginal leaders to “actually be really mindful about unconscious bias in policy development and decision making… you have a responsibility that when you’re writing policy and implementing policy, it actually needs to benefit the people that least look like you”.

6.2.4.3 Impact on the workforce

Insecure employment was highlighted as a major issue for the CTG workforce. The lack of long-term funding, the cuts to Aboriginal health and tokenistic approaches to policy implementation were consistently described by both Aboriginal and non-Indigenous participants. One Aboriginal participant stated:

> "I have 17 days left on my contract without knowing if [the program] is going to be refunded… It is incredibly stressful". They also explained that the unpredictability of funding "is not great for holding onto staff. I've just had a social worker resign last week… she said, look, the uncertainty is too much for her… they've got responsibilities financially so it doesn't surprise me that people are putting their families first, which is a shame because we lose a lot of knowledge. We lose a lot of contacts. We lose a lot of passion and drive that these people carry. They come into this job with the intention, the motivation, the initiative, the passion to want to make this change, but are constrained".

Another Aboriginal participant added that recruiting Aboriginal staff to grant funded positions was challenging and that the insecurity "is actually detrimental to Aboriginal health... it's just an absolute nightmare for us so sustainable funding is a big thing here".

For the Aboriginal participants who have stayed involved in policy implementation, they reflected on their motivation to be there for "our mob, [they] need us". This sense of responsibility and purpose was reflected in comments such as "they need us to help them through navigating services, need us to carry them emotionally. We are the ones that are standing there saying 'you have options when [the department] are coming to take your children, do you know you could ask these questions? When police stop you, do you know you can ask these questions?" The role adopted by this participant was described as "like being a stick in the mud". The image they portrayed was that they provided stability in both a fluid workforce and a vulnerable community. The challenge presented was that Aboriginal workers "live and breathe it… it's doesn't stop unless we're sleeping". One participant went on to explain the importance of Aboriginal staff supporting one another in "Aboriginal ways of knowing and being". An Aboriginal worker explained "my friend [my workmate] is home to me because we're both in that same struggle. We're both those sticks in the mud and it wears and tears on us as well but we remind each other, you know, 'its five o'clock now sis, that's it'. A key feature of their support was their reliance on culture. One participant explained that "culture isn't a privilege, it's a lifeline". They clarified that culture can be a "type of armour for survival…

so we speak a lot of language together, [share] a lot of stories, teaching around some of the values of kinship”. For this participant, culture provided some protection from racism and the lack of cultural safety in policy implementation.

Importantly, Aboriginal staff were described as crucial to successful CTG policy implementation. There was consensus among all participants that “Aboriginal people prefer Aboriginal workers”. One participant explained that “employing Aboriginal staff members is part of building community capacity and it incorporates culture into the mainstream society. Transmission of cultural knowledge, languages and cultural experience through activities and excursions; this is what happens when we employ Aboriginal people”. Aboriginal staff who implement policy in community are seen as “positive role models” and they play a vital role in the delivery of culturally safe services. One participant explained “our staff are part of the community, so they know the [children and families] coming in. They know that they’re going to be welcomed when they come in, that’s so important. To make a service accessible is just so, so important”. These participants working among the community reflected on the importance of relationships in ensuring services remain welcome and safe. Aboriginal staff “know what’s going on… whether there’s been a funeral two days ago, or whether someone is dying in hospital… Community dynamics really come into play with how you come across and pitch something… having a fun day when you’ve just lost a significant elder the day before – no one’s going to come, plus you might actually damage your relationship with community because it’s disrespectful”.

6.2.5 Understanding power in policy implementation

Participants reflected on the position of Aboriginal people as ‘other’ within policy and implementation processes. One participant acknowledged the “othering” of Aboriginal people when they explained that “for too long we’ve been on the periphery of society”. Another participant argued “we’re always bastardising every Aboriginal experience to be a negative experience, you know, always a deficit model approach to things”. One participant argued “the white way of doing things is the dominant way of doing things… especially in government”. Participants agreed that this dominant position reinforced by policy was not consistent with a vision to close the gap in health inequity. One participant explained “closing the gap to me isn’t about making Aboriginal kids [more like] non-Aboriginal kids and assimilating our community. It’s not about that. It’s about being fair and equitable to these kids who have nothing. It’s about acknowledging that there is no economic base, that we’ve been discriminated against, we always have been”. Many participants agreed with this and they argued that the power imbalance is bound to the underlying causes of inequity. One participant described the CTG strategy as a “Bandaid for a bullet wound kind of thing. Unless you’re going to take that bullet out then it’s not going to have any sort of advancement in closing the gap until some of those issues are dealt with”.

Participants also discussed the government’s position of power over Aboriginal people as open to challenge. They advocated for a shift in power to occur so that there is “unlearning about how to write policy”. One participant argued that political positions as well as “reasonings of wanting to help” influence policy and implementation. Without reflection or unlearning, policy actors “come in and out, if you’re only in it for your own selfish reasons, then you generally do more harm than good”. Aboriginal participants recognised that they did not want to rely on the “goodwill” of non-Indigenous leaders in policy anymore. Participants explained that the goodwill or good intentions of non-Indigenous leaders in health and education can be eroded because too often, Aboriginal health “is [put in] the too hard basket, and so they shy away from it because they don’t have any knowledge… Like I said, you can’t expect people to make good decisions and do the right thing if they don’t have the knowledge and the tools to be able to do it.”

Participants described power imbalances as a barrier in policy implementation that is difficult to overcome because “you’re born into that kind of thing and unless you are doing some really deep, critical engagement to decolonise” the barrier to equitable policy implementation remains. One participant stated that “I think people in Australia are happy with the status quo, they like Aboriginal people to be in a certain place in a certain way and have a certain level of control… I think people do like that, and they’re comfortable with that”. One participant explained that power is comfortable for the people at the top. They shared a powerful metaphor of the way policy can be perceived differently in relation to positions of power. They said “like a tree of monkeys, the ones up the top look down and see smiling little faces. The ones down there look up to see arseholes; that’s how it is”.

6.2.5.1 Understanding fear in policy implementation

The concept of fear emerged in participants’ comments on child removal, fear of assimilation and fear of the health system. “Most Aboriginal people are scared to go to the doctor”. This is consistent with the experiences of racism and lack of cultural safety described by participant throughout policy implementation and service delivery. The “fear of assimilation” was embedded within comments on the pressure to conform to a mainstream model of policy implementation and practice. “I worry about assimilation. I think we can work together in this community, in this country, but if you take their right to be Aboriginal away from them, then what have they got left?” Participants reflected that the fear of assimilation weighs heavily on the Aboriginal community who are fighting for their cultural identity, as an essential part of their ‘being, belonging and becoming”. The fear of accessing health services and assimilation was described as a factor influencing engagement in a range of services, including early childhood education, “services that really provide critical support at a time when families are in the most vulnerable situations”.

These fears are represented and amplified within the history and ongoing removal of Aboriginal children from families. Child removal was described as “the elephant in the room”, meaning that it is problem that everyone knows is there but one that is not addressed within the CTG strategy. One non-Indigenous participant explained “we’ve got over 3500 children in out of home care – in the last 10 years it’s doubled. Families are so fearful… they’re so worried about who’s going to see what, who’s going to judge, could they report? It’s a huge fear within families”. An Aboriginal participant agreed that “child removal from Aboriginal families is at such a high rate… our families are still being split and nobody’s there”. They went on to describe the limitation on services to families who are vulnerable. Without adequate services to prevent child removal and build capacity within the community, “they’re going to miss out on advocacy at the table with child protection. They’re going to miss out on exploring the possibilities of how they can be supported and really sort of commit themselves to the sort of programs with somebody supporting them”. Another participant suggested that fear paralyses families and they are unable to seek the support that they need “to ask questions, ‘am I doing this right?’ or share ‘I’ve got this problem. I’ve got this issue’, or say “things aren’t okay at home?” These findings suggest that the silence on child protection and children removal in the CTG strategy is a key barrier to success in policy intended to reduce gaps in health and education outcomes between Aboriginal and Torres Strait Islander children and non-Indigenous children.

Participants identified that trauma is an underlying factor generating fear. An Aboriginal participant explained that trauma has been passed down through generations and as a result “there’s lot of Aboriginal people out there now who feel like they don’t belong anywhere, and they’re lost because they’re lost in hurt”. One participant described the ongoing impact of colonisation as an “inter-generational disruption” to culture, identity and parenting. For example, “we need to realise that when we stole so many kids, how we learn to parent is how we’ve been parented ourselves… why do we think that the next generations going to come along and they’re just going to get it?” They advocated for a collective response that supports families to “ultimately circuit break [the trauma] and dismantle some of the disruption and sadness”.

6.2.6 Understanding Aboriginal childhood in Southern Adelaide

Rather than focus on rights to an Aboriginal childhood, participants in Southern Adelaide explained in detail what they envisioned an Aboriginal childhood looks like. For example, they said “we want our children to be proud of who they are”, “to be connected to family, connected to culture, connected to identity”, and “not to miss out on anything”. Another participant explained that an Aboriginal childhood should support identity so that -

> “they know about their culture. They’re going to be the future generation. They need to know what’s behind them, where they come from. They’re the first peoples of this country. They need to know who they are. They have to explore culture. They need to be able to feel and be at peace”.

Indigenous language and understanding cultural practice were seen to be a critical part of cultural identity but “it was taken away from us to assimilate… That’s not a good enough reason to strip somebody of their identity”. This participant went on to provide an insight into cultural practice and connection to country. They said “In Aboriginal culture, when Aboriginal people go hunting, they would sing to the bush because that’s their connection to land. That’s a connection to all that around them are living. Children need to feel that connection and our ancestors need to hear them, so they need that”. This reflects Indigenous knowledge and reveals a way of understanding of life and health that participants described as inconsistent with mainstream models of health and education.

Another example of the different ways of understanding childhood was seen in the descriptions of raising small children. An Aboriginal participant explained their experience was that “Aboriginal babies are more likely to get held upright, so their necks get stronger earlier… they might be able to be settled by more different people, and they might be passed around more, but it’s safe”. They went on to share that “you don’t make kids cry so putting a kid in the bedroom and shutting the door and leaving them crying, I would get flogged for that. My mother would come in or my family would come in and go ‘what the hell are you doing?’ and pick baby up”. Participants expressed their frustration with the way they see Aboriginal families being judged on their parenting by expectations and norms that are more aligned to a western knowledge of raising children. One participant explained that government workers can come in an Aboriginal family home to assess living conditions and child safety. They “look around the house, have they got this, have they got that, have they got a baby’s room set up and are they ready? It’s all on a white lens”. They explained this is not just a result of individual bias, but it reflects a system of “education, experience, what they’ve been told to look for” that does not understand Aboriginal ways of knowing, being and doing. They shared, “in the old days on welfare you walked in to a house, if there’s no food in the cupboards the kids get taken away. Yeah, but it’s an off-pay week we go to Aunty’s to eat, and then on our pay week, she’ll come to us and her cupboards will be empty”. A non-Indigenous participant observed that Aboriginal families “just shut their mouth until you get the hell out of that house and off you go”. Another non-Indigenous participant reflected on the different ways of raising children, and that this is not well understood by mainstream services even though “Aboriginal culture has survived 60,000 plus years, to do that you have to have got raising children right, so we have so much to learn [from Aboriginal culture and knowledge] really”.

Participants also identified that one of the biggest barriers to the right to an Aboriginal childhood is the removal of children from Aboriginal families. One participant explained “when you look at what actually transpires in statistics, there are incredible rates that Aboriginal children are being taken away from their families, so we don’t do enough around prevention, early intervention in supporting vulnerable families, particularly Aboriginal families”. This was recognised by participants as a gap within the CTG strategy because they are no targets specifically measuring the numbers and experiences of Aboriginal children who are removed from their families, or investment in prevention of child removal through CTG policy implementation.

6.2.7 A vision for policy implementation

In my field notes, I reflected on the hope expressed by participants despite their anger or hurt at the limitations of policy and the barriers to effective implementation. This was most clear to me during Reconciliation and NAIDOC week events where children from both Taikurrendi and Christie Downs Kindergarten would sing and dance on stage together. This example demonstrated that despite past conflict, frustration and anger with many aspects of policy implementation in Southern Adelaide, participants held on to a vision for collaboration and improving health in early childhood. Many of the Aboriginal participants argued that the commitment for truly collaborative policy that addresses underlying causes of inequity would result in “more pride in Aboriginal history, achievement” and “appropriate recognition of knowledges… a melding, merging of the best of both worlds… a much better reconciled system”. Participants recognised that this would require “a cultural shift [where] policy writers and policy makers would look at things differently”, because “more of the same won’t make any difference”. One participant advocated that non-Aboriginal people “need to step back and enable Aboriginal people to lead”. Participants advocated for Aboriginal leadership and control within long-term or recurrent funding. One participant explained “if it’s working, make it stick. Let us take care of our families. They’re listening to us, we’re listening to them. We’re getting results, like how is that not worth noting?!” The investment in ongoing services was seen as crucial because “the community need to see you as a consistent service. One of the worst things you can do is start something and then stop. It’s start-stop. There’s no consistency so the community don’t have faith in any services and unfortunately, the system isn’t very good at making those types of things happen”. Ultimately, participants agreed that the CTG strategy should be implemented in ways that “move beyond racism and social injustice” and that healthier communities would be “happier” communities. One participant described a vision for health in which “people will enjoy life more. You’re not going to be anti-social, you’re not going to want to escape your reality by using drugs or whatever, You’re going to be more community involved, caring about what’s going on around you and having time to care about those things… it could change dramatically and if our non-Aboriginal counterparts were able to see and experience who Aboriginal people really are – the country would be in a much better place”.

6.3 Chapter Summary

Participants in Southern Adelaide explained that rapid introduction of the CTG Strategy, which coincided with significant cuts to Aboriginal health, results in uncoordinated implementation and poor consultation. Community expectations for an Aboriginal children’s centre were unmet however the mainstream position of Taikurrendi appears to have secured the sustainability of an Aboriginal focused children’s’ centre in Southern Adelaide. Participants were sceptical of the influence of non-Indigenous non-government organisations based on their experiences of the imbalance of power and fear of racism and discrimination. Aboriginal workers in Southern Adelaide described the impact of policy implementation which was both seen as a burden and responsibility. Participants envisioned a right to an Aboriginal childhood, focusing on more reconciled community and early childhood services where the resilience of Aboriginal people and communities could influence policy implementation.

CHAPTER 7: DISCUSSION

In this Chapter, I discuss the findings of the research in light of the policy analysis (Chapter 4) and the two case studies (Chapter 5 and 6) to answer the following research questions:

1. To what extent are Indigenous rights prioritised and acted on within the ‘Closing the Gap’ strategy in early childhood?
2. To what extent are social determinants of Indigenous health recognised and acted on within the implementation of ‘Closing the Gap’ strategy in early childhood?
3. How does the experience of the ‘Closing the Gap’ strategy in early childhood compare in Shepparton (Victoria) and Southern Adelaide (South Australia)?
4. To what extent has a decolonising approach to health equity been implemented through the ‘Closing the Gap’ strategy in early childhood?

To begin I draw out key themes that emerged from the policy analysis and case studies. The analysis presents the CTG strategy as a “Bandaid for a bullet wound” in which the policy and implementation do not address the underlying causes of poor health as it affects Aboriginal and Torres Strait Islander people and children in particular. I go on to outline how the CTG strategy in early childhood has been implemented in ways which recognise and name Indigenous rights, where Indigenous rights are implied, and where Indigenous rights are undermined or ignored. Then, I discuss how the research findings highlight the importance of prioritising social determinants of Indigenous health in order to promote health and well-being of Aboriginal and Torres Strait Islander children and families. Approaches to policy implementation that reflected a rhetoric of “working with” Aboriginal people are identified as tokenistic by both Aboriginal and non-Aboriginal participants and I conceive of this as an example of ongoing colonisation. I explore the way that an Aboriginal childhood is framed in policy and how Aboriginal people are represented through a paternalistic and deficit lens. I then go on to discuss the concepts of power and sovereignty. In these sections I discuss power by drawing on research led by Aboriginal scholars Bond (2009, 2017a, 2017b, 2017c); Bond et al. (2019); Bond and Singh (2020), and Moreton-Robinson (2006, 2007, 2009b, 2015), influenced by a Foucauldian perspective on power. At the end of the Chapter I outline the limitations of the study and provide an overall summary of the discussion.

7.1 Synthesis of the research findings

This research has shown that implementation of the CTG strategy in early childhood varied depending on the way in which rights were recognised, and how power was exercised at the local level. In Southern Adelaide, the rapid introduction of the CTG strategy, cuts to Aboriginal health services, and the mainstreaming of early childhood services, influenced the extent to which Indigenous rights were recognised and acted on, and the way that action on the social determinants of Indigenous health was prioritised. Following implementation of policy, service providers expressed frustration with both the process of consultation and the drifting of policy implementation away from processes consistent with Indigenous rights and self-determination into a more limited model of mainstream service provision. In these ways, the influence of government power over Aboriginal people was recognised as a barrier to closing the gap in health inequity.

In Shepparton, a history of collective action and advocacy supported Rumbalara to be known as a place for the community to belong, indicating that the role of an Aboriginal controlled organisation extends beyond the provision of health and community services, and enables community-led actions to exercise rights and address social determinants of Indigenous health, although in limited ways. Barriers to the recognition of Indigenous rights and promoting action on the social determinant of Indigenous health were seen in the structural constraints, complex funding arrangements, the burden of over-reporting, and different perspectives on partnerships. The influence of Aboriginal leaders and service providers was seen by participants in Shepparton as an act of self-determination. Even though leadership at Rumbalara has changed multiple times during this research, Aboriginal participants still advocated for Aboriginal-controlled early childhood services as best positioned to respond to locally identified needs. In comparison, Southern Adelaide lacked the stability of an Aboriginal community-controlled health organisation in the region and then relied on the influence of leaders within early childhood services in a mainstream model where services are universally accessible and include targeted approaches in health and education for Aboriginal children.

7.1.1 “Bandaid for a bullet wound”

In both case studies, participants recognised the limitations of the CTG strategy, best captured by a South Australian participant who described CTG as a “Bandaid for a bullet wound”. As shown in my research findings, Aboriginal participants described wounds stemming from racism, ongoing colonisation and power inequalities, the deficit discourse, and silence on the removal of children; manifest within the policy relationship between Aboriginal communities and governments. In Southern Adelaide, participants compared the CTG strategy to assimilation and many explained that fear prevents people from accessing mainstream services, even when the programs offered are specifically targeted to support children and families when they are most vulnerable.

Importantly, participants from the Aboriginal community-controlled sector or services as well as participants working in mainstream services agreed that superficial solutions cannot address the underlying causes of health inequity in Australia. Participants from different services explained that policy implementation has been led by services and/or by Aboriginal community member in many forms that resist, subvert, bend or extend on policy prescriptions. This was seen in the way that Rumbalara was able to provide a government-funded health check but coupled this with broader conversations with community members about health and wellbeing. It can be seen in Southern Adelaide where Taikurrendi, despite being formed as a mainstream and universally accessible children’s centre, has subsequently developed and implemented specific programs and services for the Aboriginal community. Community members’ engagement with these services took time, and was further enabled through the perseverance and engagement of several older Aboriginal women who weave at the centre. Another example in Southern Adelaide is the bus service provided by Christie Downs Kindergarten to ensure that families can send their children to kindergarten but also workers have a chance to connect with families and offer support. The transport is very limited and at times there is no funding for this bus service but the Kindergarten find a way to make it work so that those families who otherwise could not get their kids to the service can still participate in early childhood education and connect with other Aboriginal community members.

These examples show the innovative ways that community-controlled services, other services and Aboriginal community members have shaped policy implementation at the local level, in ways that are relevant to rights and social determinants of Indigenous health. While the examples mentioned are likely to only have limited effects, they are still important actions that contribute to meeting the CTG strategy targets. However, they do not have the capacity to address the more fundamental limitations of the CTG strategy exposed by this research. For example, in the policy analysis I explained that targeting all Indigenous children to be enrolled in early childhood education is only one part of addressing health inequity. This underlying assumption is that the target of enrolment is linked to a linear, predictable process of participation in the education system. The relevant policy silence for children concerns the need for engagement and recognition of social determinants of Indigenous health such as culture, language, and identity. Moran (2016) describes the type of contrast between the enrolment target and complexity of engagement as a mismatch between policy and practice. Importantly, at the local level, service and community-led actions to shape policy implementation in both case studies were focused more on engagement, culture, language, and identity. However, because the targets of the CTG strategy do not address the causes of disadvantage or discrimination, and do not dedicate attention and resources to these determinants of Indigenous health, policy implementation can only be bent so far. The examples of service and community-led actions to improve policy implementation described above indicate the potential for policy to address rights and determinants of Indigenous health far more effectively through co-design with Aboriginal people working within services or providing community leadership regionally.

7.1.2 Wounds of ongoing colonisation

The lack of broader or deeper policy solutions to address the wounds of colonisation also led to policy implementation that was lacking Indigenous voice or knowledge. Participants in Southern Adelaide expressed frustration that CTG funding was funnelled into non-Indigenous non-government organisations without support from the Aboriginal community resulting in a lack of transparency and a lack of trust. Some participants expressed deep concern that the community's unmet expectations during the implementation of the CTG strategy would further erode trust between some families and the early childhood services. A source of distrust clearly evident in the implementation of the Indigenous Advancement Strategy (IAS) occurred when non-Indigenous organisations were funded for programs, despite having little or no connection to Aboriginal communities. This was identified in Australian National Audit Office (2017) report on the IAS which concluded that the strategy had not been effectively implemented, and that the planning and design of the IAS were rushed, which impacted on establishing arrangements and structures that focused on the prioritising the needs of Indigenous communities. In addition, the audit found that the billion dollars spent in the first round of funding was not administered correctly resulting in limited assurance that the projects funded could support the desired intent of the IAS. The audit highlighted inadequacies in consultation processes risk management, implementation that was not targeted to respond to needs at a local level, and that partnerships were not established as required for funding. The criticism by the Auditor-General of the IAS grant administration process was scathing, indicating that there were problems with staff training, scoring of grant applications, quality control, breakdown of communication and inaccurate reporting. Even though recommendations regarding the implementation of the IAS from the Australian National Audit Office (2017) were all accepted by the responsible government department, the damage to services who had their funding cut, and the impact on communities had already deepened the wounds.

7.1.3 Hope for Indigenous rights, self-determination and social determinants of Indigenous health

Despite the disappointment with the CTG strategy, Aboriginal and non-Indigenous participants from both case studies expressed in various ways an underlying commitment to policy and social change consistent with principles of Indigenous rights, self-determination and action on the social determinants of Indigenous health. Geia, Hayes and Usher (2011) described the commitment to successful policy implementation as a spirit of goodwill to build partnerships so that Aboriginal community members, government and non-government organisations can work together to attain good health outcomes for children and families. In both the Shepparton and Southern Adelaide case studies there was a belief that actions at the local level would influence the local community and reframe the deficit lens in policy and implementation. The focus for positive action was not overtly on a policy or the bureaucratic processes by which policy is implemented, but on the local people, the children and families who need support and equitable action on social determinants of health. For example, in Southern Adelaide there was hope for unity in the community and shared joy when children from Taikurrendi and Christie Downs Kindergarten performed together at Reconciliation week and NAIDOC week events. These acts of solidarity despite the past community conflict and unmet expectations in the early childhood education sector, demonstrate that the Aboriginal people involved in my study have held on to hope even when implementation occurs within mainstream models which limit Aboriginal control and self-determination and marginalise Aboriginal voices.

This hope is reflected in the street murals in Shepparton that honour Aboriginal leadership, advocacy and contributions to the Aboriginal community (Greater Shepparton City Council, 2018). Pastor Sir Doug Nicholls was one of the Elders immortalised in the mural. In a short film produced by Dickson (2017), Pastor Sir Doug Nicholls' family share his story, beginning with his birth at the Cummeragunja mission. As an adult he stood up against racism in sport, became a leader in the Christian church, was instrumental in advocacy for the referendum in 1967, and became the Governor of South Australia. Grandsons of Pastor Sir Doug Nichols described his legacy as one of integrity, compassion, rights, and an example of how to meet injustice head on. Through his activism, Pastor Sir Doug Nicholls also fostered hope for reconciliation. For example, he said "to get a tune out of the piano, you can play the black notes, and you can play the white notes. But to get harmony you've got to play both" (Amnesty International, 2017). This quote is displayed with the mural in Shepparton. His hope remains alive in the lives and words of participants in this research, even though they are still advocating for the recognition of Indigenous rights in policy and through the way that policy is implemented.

7.2 Policy implementation and recognising Indigenous rights

I identified that processes of CTG policy implementation in early childhood can be grouped in the three ways, similar to the differing degrees of recognition of rights revealed through the policy analysis. These are implementation processes that occur:

1. through mainstream health and education services;
2. in ways that specifically target Aboriginal children and families; and
3. through Aboriginal community-controlled health and education services.

Although the ways that policy is implemented in a particular sector or locale may involve a mix of these approaches, examining specific actions in this light can provide insights about how and why implementation does or does not address social determinants of Indigenous health and Indigenous rights. For example, Taikurrendi in Southern Adelaide exists as a service within the state government's education department, i.e. as a mainstream service. The centre was established under a National Partnership Agreement within the CTG strategy, but is universally accessible to all children in the community. Leaders at Taikurrendi have maintain a focus on the health and education of Aboriginal children, therefore programs facilitated through Taikurrendi target Aboriginal children and families. The discretion demonstrated by Taikurrendi staff within the education department represents them acting as street level bureaucrats. This was first described by Lipsky (1969) as a way of implementing policy at a community level, and where citizen interests are represented by street-level bureaucrats acting as liaisons between community and government. However, according to my analysis, because Taikurrendi was not established as a community-controlled service as was initially expected by the local community, Indigenous rights are only recognised partially and indirectly via targeted support to Aboriginal children and families, relying on the influence of centre leaders, rather than more fully through a community-controlled model, enacting a principle of self-determination. When policy and implementation does not support the fuller expression of rights though community-controlled services this can also have adverse consequences. In Southern Adelaide, the unmet expectations led to conflict within the community and between service providers.

The findings from this research on the inconsistent recognition of Indigenous rights in the CTG strategy in early childhood is consistent with two studies published respectively during the first and second iterations of the CTG strategy by Smith (2007) and Lavoie and Dwyer (2016), which argued that self-determination was not a priority for the Australian government. Fisher et al. (2018), also argued that the incomplete funding provided for the National Aboriginal and Torres Strait Islander Health Plan (a key part of the broader CTG strategy) demonstrates a lack of commitment by the Australian government to enact policy that promotes social determinants of Indigenous health.

The significance of this prioritisation of a mainstream or targeted approach was made clearer in the research through understanding the alternative approach to policy implementation occurring in Shepparton where Lulla’s Children and Family Centre (Lulla’s) was established, and is now managed, by Aboriginal people for Aboriginal people. The pride of community members in Lulla’s expressed a connection to the legacy of Lulla herself and (as with Rumbalara) a sense of belonging, community identity and confidence that extends beyond the simple provision and use of a service. It is these additional benefits of a community-controlled service that are highly valued by community members and arguably important for their health and wellbeing, but largely invisible in the structures and procedures of CTG policy.

The children’s centres in both case studies promote early childhood health and education in a way that includes identity, belonging and culture; thus, prioritising social determinants of Indigenous health. Lulla’s also has a standing within the community whereby non-Indigenous organisations and government department seek support or advice from Lulla’s on issues relevant to Aboriginal childhood. For Aboriginal families, the history and ethos of Lulla’s ensure that it is a safe place for families and their children. In Southern Adelaide there is this same sense of history at Christie Downs Kindergarten where multiple generations of Aboriginal families have attended. The rapid roll out of the CTG strategy in Southern Adelaide coinciding with cuts in Aboriginal health and the marginalisation of Aboriginal leaders, meant that the legacy of Kaurna leadership, and the importance of generational engagement at Christie Downs was not prioritised, but instead Taikurrendi was established as a new mainstream centre. One result of this is that Taikurrendi is more strategically positioned than the older Kindergarten service to develop partnerships with external agencies in both the education and health sectors. The separate existence of these two Southern Adelaide early childhood services created community conflict which drew community and policy actors’ attention away from the importance of an Aboriginal children’s centre run by and for Aboriginal people. I have observed the community celebration when children from both centres sing and dance together during Reconciliation or NAIDOC week, but on deeper analysis, it does not heal the underlying conflict or modify the underlying policy attitudes and practices that (blindly) contributed to that conflict.

Both of the Southern Adelaide early childhood services for Aboriginal children are locked in to the mainstream. My research shows that, in this structural position, actions for social determinants of Indigenous health will depend on the influence of leadership, and Indigenous rights can only be enacted in partial, limited ways. It is important to note that even though Indigenous rights are more clearly and fully realised within the practices at Lulla’s in Shepparton – meaning their programs are well-placed to improve the health of Aboriginal children and contribute to CTG targets – the centre faces significant challenges in securing ongoing funding. Lulla’s position outside the mainstream contributes to making them vulnerable to insecure funding and all of associated stressors for staff and community outlined in the results Chapters.

In both case studies, the early childhood education services are positioned to contribute to the health and well-being of Aboriginal children and families despite Indigenous rights not fully being recognised.

7.2.1 Human rights and Indigenous rights

These examples of policy implementation in early childhood demonstrate the way that human rights can be recognised in policy without the same commitment to recognising Indigenous rights, especially the right to self-determination. All children have the right to early childhood education. This is reflected in universal access to children centres and kindergartens, including those with a focus on supporting Aboriginal and Torres Strait Islander children and families. However, the policies analysed, in effect, preference the right to universal access over Indigenous rights. In explicitly structuring early childhood services through a mainstream system instead of advocating for services to be run "by Aboriginal people for Aboriginal people" (as promoted by research participants in both case studies), Indigenous rights remain silenced in policy. This example of prioritising mainstream service provision over Aboriginal-controlled services is consistent with the argument by Cooper (2011) that many Australian government policy actions breech the Declaration of the Rights of Indigenous Peoples regarding self-determination, participation in policy implementation, and the ability to practice and maintain culture. As a result, actions at the local level to address social determinants of Indigenous health and promote Indigenous rights were dependent upon the influence of leaders and service providers who supported the importance of culture, identity and belonging in childhood, even when these actions were not prioritised in the CTG strategy. The literature reviewed also showed that such mainstream approaches to service provision for Aboriginal and Torres Strait Islander people risk not being able to responding to local issues (Lavoie, 2014), are tokenistic (Ronald & Koea, 2013), or even reflect models of assimilation (Cooper, 2011; Sullivan, 2011).

7.2.2 The inconsistent recognition of Indigenous rights across a spectrum

In the policy analysis (Chapter 4), I explained how Indigenous rights are named and recognised, implied, undermined or ignored within the array of CTG policy documents related to early childhood in both iterations of the CTG strategy. I described the recognition of Indigenous rights in the policy documents as a spectrum to symbolise complexity and inconsistency in the way that none of the policy documents fully recognise Indigenous rights and none of them totally undermine Indigenous rights. The examples of policy implementation from the case studies show that when policy is implemented in a mainstream context, Indigenous rights are more likely to be undermined or ignored. Indigenous rights are implied when programs or services target Aboriginal children and families but a stronger recognition of rights is limited by the lack of self-determination or the absence of community-controlled services. At the other end of the spectrum, Aboriginal controlled health and education services name and recognise Indigenous rights, including the right to self-determination. Like the policy documents themselves which fall across the spectrum of recognising rights, implementation is also mixed.

Just as with the findings of my policy analysis, implementation in the mainstream does not always undermine Indigenous rights, and may support human rights, yet at the other end of the spectrum, Indigenous rights are not able to be fully recognised due to ongoing colonisation (Cooper, 2011), the fact that there is no treaty between the Commonwealth and Aboriginal and Torres Strait Islander people, and no constitutional recognition of Indigenous rights in Australia. My research indicates that the absence of full recognition of Indigenous rights in the CTG strategy acts as a barrier to more expansive and comprehensive realisation of Indigenous rights in implementation, because it prevents actions such as a systemic commitment to well-resourced, Aboriginal community-controlled services.

7.3 The importance of prioritising social determinants of Indigenous health

Culture has always been, and will continue to be an essential part of Aboriginal health and well-being (Carson et al., 2007). In the policy analysis, I identified that positioning culture at the heart of the National Aboriginal and Torres Strait Islander Health Plan and associated Implementation Plan emphasised the importance of culture to health and supports the recognition of Indigenous rights. When participants from both case studies described a healthy community, they focused on respect for culture and belonging where children can grow up strong in language, identity and kinship. Prioritising culture and connectedness is also reflected in the literature on social determinants of Indigenous health. As outlined in the literature review (Chapter 2), according to Kingsley et al. (2018), Aboriginal culture is based on relationships that connect people, ancestry, identity and kinship. This is reflected in connection to country (Kingsley et al., 2013; McIntyre-Tamwoy et al., 2013; Pickerill, 2009) and Kingsley et al. (2018) explained that many Aboriginal people in the state of Victoria “may not be living on their ancestral Country, but find ways to connect back to their Country, as well as connect to and respect the Country they are living on” (p.212). Raman et al. (2017) highlighted that cultural engagement is a major factor in the healthy development of Aboriginal children. A study by Priest et al. (2012) found that for Aboriginal children, culture was seen as an ultimate source of knowledge, meaning and strength, essential for growth. They explained that “being proud and strong in their Aboriginal identity was identified as an important foundation for children's successful participation in life, as a source of moral knowledge and of guidance with regard to children learning responsible and healthy behaviours, and essential to self-esteem" (p.184). However, in my analysis of the policy documents (Chapter 4), I noted that culture is not consistently prioritised in policy. Findings from the case studies (Chapters 5 and 6) showed that the prioritisation of a mainstream approach in policy implementation diminishes a focus on culture, even though participants agreed that a focus on social determinants of Indigenous health promotes identity and belonging for Aboriginal people and strengthens communities. For example, participants from both the Aboriginal controlled and mainstream non-government organisations in Shepparton clearly reported that Rumbalara's depth of interaction with community could not be replicated by other service providers in the region. The strength and importance of culture as a determinant of health was recognised by both Aboriginal and non-Indigenous participants in the study. Rumbalara was seen to be a place where people belong and connect to country and culture. This is consistent with the findings of Kingsley et al. (2018) who explained that places of gathering and belonging support community to feel connected, build identity and self-esteem, and cultivate resilience. Their research showed that Aboriginal people in the state of Victoria rely on these connections for healing and for a place to "come and be ourselves, be Aboriginal… just share cultural understandings" (p.216). In Southern Adelaide, Aboriginal participants spoke earnestly and some with tears in their eyes, wishing for a local service where they could belong, and where culture was regarded as a strength. They understood the role of targeted health services such as the family clinics at Noarlunga and Clovelly Park, but the Southern Adelaide participants recognised that the service bound up in the mainstream restricted that sense of belonging for the Aboriginal community. The prioritisation of mainstream services missed the opportunity to implement policy in a way that prioritises an Aboriginal understanding of health and self-determination.

7.4 The rhetoric of "working with" Aboriginal communities

Hunt (2013) identified that effective engagement of Indigenous peoples in policy implementation requires an appreciation and valuing of Indigenous culture and knowledge, shared decision making, actions based on Indigenous aspirations and strengths, with clarity about processes and outcomes. In many of the CTG strategy Prime Ministers' reports there is a repetitive narrative that "true gains are made when Aboriginal and Torres Strait Islander people are able to work with governments to set the agendas that impact their wellbeing"

(Commonwealth of Australia, 2017, p. 10), and “services need to be designed, developed and implemented in partnership with Aboriginal and Torres Strait Islander people” (Commonwealth of Australia, 2018, p. 8), however this was far from the experience in each case study. Instead, policy actors had to bend policy implementation in ways so that when conducting health screening, they were also able to consider other factors relevant to the community, and inclusive of social determinants of Indigenous health. Even when government reports clearly state that “when governments listen, collaboration puts Indigenous Australians at the centre of decision-making, builds capacity of individuals, organisations and communities, and enables people to make decisions to support their wellbeing” (Commonwealth of Australia, 2017, p. 10), it does not mean that such approaches are implemented in local communities. Moran (2016) argued that “no matter how well policy is conceived, delivery on the ground is where it counts, and where it consistently fails” (p.13).

This rhetoric of “working with” was prominent in the Southern Adelaide case study results as participants from both the government and community described consultation for policy implementation as a tokenistic “tick the box” type of activity where governments are “not really listening”. Tokenistic approaches in policy implementation are characterised by a low level of participation, close to manipulation, where the real objective of engagement is not to enable participation, but to educate or inform (Arnstein, 1969; Talbot & Verrinder, 2014), and reinforce a colonial apparatus (Moreton-Robinson, 2007, 2015). Johnson, Lawn, and Struber (2012) explained that tokenism occurs when power-holders seek input from the community but the method of participation means that community views are not heeded by the power holders. This was evidenced in consultation by the state government’s education department in South Australia, where community members expected their views to be heard and taken into account but these expectations were not met. According to Aboriginal participants, while some members of the Aboriginal community understood that Taikurrendi was planned to be positioned within a state government department, others were still expecting Taikurrendi to be a children’s centre for Aboriginal children and families, and not the universally accessible centre it became. The frustration expressed by some of the Southern Adelaide participants reflect their individual experiences of tokenistic consultation by state government departments. In this example of consultation in South Australia, there is little evidence of public servants working with the local community even participants from health and education government departments described consultation as tokenistic. The rapid roll out, hierarchical nature of reporting and the siloed nature of managerialism evident in the Southern Adelaide case study reveals that the largely rhetorical nature of “working with” also had a structural dimension.

Degrees of tokenism were also seen in partnerships between government and non-government organisations as described by participants in Shepparton. While non-Indigenous participants perceived partnerships as operating in respectful and collaborative ways, Aboriginal participants were sceptical and unconvinced that these partnerships could be equal. One participant in Shepparton compared partnerships to an ongoing master – servant relationship and that the government plays the role of “puppet masters directing what’s being said and where money goes”, reflecting a significant power imbalance inconsistent with the rhetoric of “working with” Aboriginal people. Dwyer et al. (2014) explained that the relationship of funder and provider between government and Aboriginal community-controlled services is seen to offer security to a health care system, but that a significant gap remains regarding accountability and trust between key stakeholders. They noted that the Aboriginal health sector is funded through “a complex array of short-to-medium tern funding contracts, a situation that contrasts with the mainstream health system, where essential basic care is either provided directly by government or funded through long-term fee-for-service arrangements” (p.1103). In their research, they found that even though there was a commitment from government to a more relational approach consistent with the rhetoric or “working with”, they did not detect progress towards shifting power towards self-determination. Similar to the concerns voiced by Aboriginal participants on the partnership rhetoric in Shepparton, Dwyer et al. (2014) argued that the turning the rhetoric of “working with” into action will take time to enact at the local level. The frustration for Aboriginal participants in Shepparton who were sceptical of partnerships, stemmed from their repeated experiences of this rhetoric of “working with” the community not being reflected in practice. The rhetoric was not seen as giving rise to a new approach in either consultation or policy implementation. Non-Indigenous participants recognised that working with Aboriginal people is “a sensible reframing and that’s something we should’ve been doing all along” but the Aboriginal participants suggested they would reserve judgement until they could see if anything would be different. Interestingly, despite the different interpretations of the strength and effectiveness of partnerships between services and across sectors, all participants agreed that there was still progress to be made to avoid tokenistic participation, described by Dwyer et al. (2015) and Howes and Dwyer (2016) as government ambivalence for implementing policy. Participants envisioned stronger, sustained partnerships that would move in a progressive way beyond the rhetoric.

7.4.1 The challenge of leadership within Aboriginal health

This research has highlighted external and internal challenges within Aboriginal health. In Southern Adelaide the restructuring of the Aboriginal health division marginalised Aboriginal leaders and limited the influence of Aboriginal voice in decision making. In Shepparton, Aboriginal leaders identified the structural constraints and funding models that bound them to prescriptive policy which sometimes offered limited scope for locally enacted flexibility in implementation, but ultimately restricted self-determination. In both of the case studies, Aboriginal leaders described being positioned at an interface between government and community where they are answerable to both groups. Stewart and Warn (2016) described this as leading ‘between two worlds” (p.3), one aligned to organisational reality and demands, and the other in community. This results in a process of constant interpretation and negotiation. Aboriginal participants in both case studies viewed their roles in leadership as a responsibility, and at times as a heavy burden, but always an important contribution to the community.

In the Shepparton case study results (Chapter 5), I explained that Rumbalara had experienced significant leadership change during this research project. In addition to four different Chief Executive Officers, a completely new board of directors was established in 2019 and new members completed governance training. There is optimism that Rumbalara is “now in safe hands, stronger than she has been for a very long time” (Rumbalara Aboriginal Cooperative, 2020, p. 2), and that the new executive leadership team will help the organisation and community to thrive. However, there has been no annual report published by Rumbalara since 2015-2016. The impact of the instability in leadership within Rumbalara is unknown but service provision was uninterrupted. In my study, research participants chose not to comment specifically on administration issues within Rumbalara, and focused on the ongoing implementation of policy. I reflected that all of the leaders at Rumbalara face challenge of leading “between two worlds” and their approach to programs and services within the organisation indicated that leadership is a collective responsibility, and more than the role of one person or the executive board.

7.5 Biomedical and behavioural views of health and the framing of Aboriginal childhood

In the policy analysis (Chapter 4) I explained how Aboriginal people are sometimes represented as the problem and that the CTG strategy presents a deficit discourse. My analysis of interviews from both case studies indicates that Aboriginal childhood has also been framed within the targets of the CTG strategy in a way that aligns with a biomedical, behavioural view of health, and not one that prioritises an Aboriginal view of health.

Considering biomedical and behavioural views of Indigenous health firstly, Bond and Singh (2020) argued that the CTG strategy is based on a form of bias, by being focused "disproportionately on the behaviour of individuals, suggesting that health inequalities are a product of Indigenous lack, morally and intellectually, rather than socially determined" (p.198). Levesque and Li (2014) and Malatzky and Bourke (2017) maintian that social factors including social determinants of Indigenous health also become invisible to many actors implementing policy because of an underlying assumption that scientific medicine is the only true interpretation of health. Since colonisation, Indigenous ways of knowing, being and doing, have been considered illegitimate by non-Indigenous power holders and Indigenous knowledge is therefore dismissed by biomedical or bio-developmental discourses as being inferior (Allan, Ball, & Alston, 2010; Beagan, 2003; Durey, 2015; Lupton, 2003; Shonkoff, 2012; Swain & Barclay, 2013; Viruru, 2005). Even when mainstream bodies such as the Australian Medical Association (2015) support Aboriginal community control and advocate "that all health services provided specifically for Aboriginal and Torres Strait Islander people should be designed, developed and controlled by the communities they serve in collaboration with mainstream processes", the bias against Indigenous knowledge and community control remains embedded within health and education systems. As a result, policy is written is ways that privilege the dominant majority culture in a way that is unquestioned (Dahlberg, Moss, & Pence, 2006), maintaining the status quo of colonising dynamics within policy structures. Lowell et al. (2015) reported that even when early childhood programs are based on cultural practices and Indigenous knowledge, there is an 'agenda creep' in implementation that shifts back to a biomedical domain. This prioritisation of a biomedical approach accounts for the prominence of mainstream early childhood education within the CTG strategy and the universal access granted at Taikurrendi in Southern Adelaide rather than an Aboriginal controlled service specifically for Aboriginal children. The position of Rumbalara and Lulla's as respected service providers within broader health and education system demonstrates that Aboriginal controlled organisations have an essential role in supporting the health and well-being of children, families and the community. This is another example of street level bureaucracy. O'Sullivan (2016) argued that the contested nature of Indigenous affairs policy creates considerable space for policy actor's influence during implementation. The way that Rumbalara tailored health services to meet the needs of the community indicated that policy implementers can push back against biomedical and behavioural views of health embedded within policy. Therefore, the dominant colonising bias in policy does not completely dictate implementation processes and outcomes.

Gerlach, Browne, and Suto (2014) argued that dominant early childhood development discourses are assumed to be universal, however, a generalised approach to early childhood discounts socio-cultural and historical contexts. For example, Gerlach et al. (2014) stated that childhood "has been largely defined, categorized, and decontextualized by adults from primarily a White, middle-class, and urban perspective" (p.248). My policy analysis (Chapter 4) showed that in the 'Investing in the Early Years' – A National Early Childhood Development Strategy, the focus is on neoliberalism, that is economic value, productivity and reduced public expenditure. In this policy and the five other education policies within the CTG strategy, universal access to early childhood services is a prominent feature, based on an assumption that universal access will improve accessibility, reduce stigma and create a pathway to referrals for services providing additional support to children. As stated in my policy analysis (Chapter 4), the concluding argument for universally accessible services is that they are "cost effective" (ref. p.36). In my analysis of the National Partnership Agreement on Early Childhood Education, I discussed an underlying assumption in the policy that Aboriginal children will engage in mainstream early childhood education, with a concomitant absence of policy strategies for the inclusion of culture, language or other social determinants of Indigenous health. It also assumed that simply enrolling children in early childhood education will result in engagement and did little to address potential social determinants of participation. And yet, in the most recent Australian government report on the CTG strategy, barriers to participation in early childhood education are identified as:

> "out of pocket expenses, a limited awareness of services, administrative complexity, lack of transport or locally available services, poor child health, a perception that the child is too young to participate, [and] a lack of confidence in the value of early education services or fear of racism and judgement" (Commonwealth of Australia, 2020, p. 25).

Importantly, all of the participants from service providers working directly with children in both case studies described ways they pushed back against the dominant discourse in policy to embed culture, language and identity in learning and play. For example, bush kinder in Shepparton teaches children about country, Aboriginal art and storytelling, and builds connection with the Elders who participate in these activities. Implementation that prioritises these social determinants of Indigenous health for children was dependent upon the influence of local actors, because it is not written into the CTG strategy. The Secretariat of National Aboriginal and Islander Child Care (2018) reported that the CTG strategy targets are too focused on biomedical health, mainstream education and employment. They argued that the narrow focus of the CTG strategy "is unlikely to bring about the holistic and comprehensive change that is required to achieve equality outcomes within a generation" (p. 4). The importance of non-biomedical approaches in early childhood was also supported in the international literature as Greenwood and de Leeuw (2012) in Canada explained that enhancing the health of Aboriginal children requires holistic concepts of health, moving beyond the biomedical realm so that services do not "target individual change or focus solely on proximal determinants of child health" (p.383).

The framing of Aboriginal childhood and the systemic funnelling of children into a mainstream system was brought to light through the documentary 'In my blood it runs' (Newell et al., 2019), internationally released in 2019, and promoted in Australia during Reconciliation Week in 2020. Gorey, Turner, and Vadiveloo (2020) explained the film tells a story of Dujuan, an Aboriginal child in the Northern Territory, his exclusion in education, and a "heartbreaking sense of failure". They argued that Aboriginal children rarely walk into a classroom that privileges their language and culture. This documentary depicted the education system in a way that highlighted the colonial history of brutality, fear and exclusion that sets a "trajectory [for children] towards profound risk onto a well-worn treadmill heading for incarceration, welfare and early death that devastates so many children and families" (Children's Ground, 2020, p. 27). Consistent with the findings from my research, this documentary drew attention to the systemic failures of a biomedical and behavioural view of health and education embedded within the CTG strategy that prioritises mainstream services and universal access. Aboriginal elder, MK Turner OAM argued "everyone is always saying that we need to make our kids ready for school, but why can't we make schools ready for our children" (Children's Ground, 2020, p. 27).

7.6 Problem representation in the CTG strategy

Having discussed the framing of an Aboriginal childhood, the problem represented in the CTG strategy is revealed as one of getting children to enrol in early childhood education, but not engagement or the provision of services that support a healthy Aboriginal childhood. This problem representation is prevalent in both iterations of CTG policy despite implementation being influenced by actors who promote social determinants of Indigenous health. The problem representation tacitly places responsibility for reaching the desired CTG target on children and families to enrol in early childhood services. Askew et al. (2020) described the CTG strategy as being "underpinned by a sense of urgency to bring Indigenous peoples' quality of life into line with that of non-Indigenous people" (p.102). Findings from this research show that this urgency is observed through targets that are more easily measured empirically such as enrolment, rather than more complex systemic changes in the way that the CTG strategy is structured and implemented. The invisible norms by which Aboriginal people and the CTG targets are measured uphold a principle of "normalisation" (Sullivan, 2011) and continue to problematise Aboriginal people and position them as "other" (Klein, 2015; Menzies, 2019; Moreton-Robinson, 2006; Schofield & Gilroy, 2015).

This representation of Aboriginal people as a problem to be solved is consistent with the deficit discourse in policy, strongly criticised in the literature (Brown, 2009; Klein, 2015; Sullivan, 2011). Bond (2009) argued that the public gaze has been transfixed on deficits when it comes to Aboriginal children. In 2017, she explained that the deficit framing of Aboriginal people is both the cause and the symptom of inequity, and that Aboriginal people have been deliberately excluded (Bond, 2017c). She noted that "White people are simultaneously positioned as our aspirational goal and saviours. It suggests to us that Black lives matter to them. Yet in emphasising our deviance, the sins of a system that White people uphold and benefit from remains unnamed and unnoticed". The positioning of Aboriginal children as "less-than" non-Indigenous children is seen in the construct of a 'gap' which needs to be 'closed' by Aboriginal children being brought up to the same standard as the non-Indigenous population.

This representation of Aboriginal people as the problem was prevalent in the early days of colonisation and has continued into current policy, evidenced by the forced removal of generations of children (Bishop et al., 2009; Cooper, 2011; Menzies, 2019). The Secretariat of National Aboriginal and Islander Child Care (2020) reported that as at February 2020, there were 17,979 Aboriginal and Torres Strait Islander children in out-of-home care nationally, an increase of 39% from the previous year and this number does not include children on permanent care orders or adoptions. Aboriginal and Torres Strait Islander children are now 10.6 times more likely to be removed from their families than non-Indigenous children and the rate is projected to double in the next 10 years. The increasing numbers of Aboriginal children in out of home care in Australia was highlighted by participants in both case studies as an issue that should be included in the CTG strategy. I identified this as a silence within the CTG policy documents. Another notable silence within the CTG strategy is in the criminal justice system where Aboriginal and Torres Strait Islander adults constitute 27% of the national prison population (Australian Law Reform Commission, 2018) and 53% in youth detention (Australian Institute of Health and Welfare, 2020). The rates of Aboriginal children in out of home care has increased during the decade of CTG policy implementation (Wahlquist, 2018), suggesting that the current approaches to supporting children and families is not meeting community need. The Secretariat of National Aboriginal and Islander Child Care reported that projections show that the number of Aboriginal and Torres Strait Islander children in out of home care could triple in the next 20 years if current conditions remain the same and significant policy reform is not implemented to interrupt the trajectory (Secretariat of National Aboriginal and Islander Child Care, 2018).

There are examples in the literature from New Zealand of decolonising policy resulting from the Treaty of Waitangi (Dwyer et al., 2014; Lavoie et al., 2012; Meo-Sewabu & Walsh-Tapiata, 2012; Munshi et al., 2016; Ronald & Koea, 2013). Mutu (2018) argued that the Treaty of Waitangi does not do enough to restore Indigenous rights in New Zealand even though this Treaty provides a legal platform for incorporating Māori values and ideology into social and health policies. This incorporation of values and ideology shifts problem representation away from Indigenous people as a problem, and there is greater respect for collaboration. The closest examples from this research to decolonising policy within the CTG strategy is the National Aboriginal and Torres Strait Islander Health Plan and the associated Implementation Plan. However, as I explained in Chapter 2, these policies have not been fully funded or implemented as designed (Fisher et al., 2018). Fredericks (2011) argued that decolonising health policy requires Aboriginal people having control and participating in decision making, administrative process and service delivery. She wrote, ““It can be demonstrated that when Aboriginal people moved from being seen and treated as objects of policy to be subjects who themselves have a stake in policymaking, there was better control over health outcomes" (p.92). Even though the Indigenous right to self-determination is not prioritised in the CTG strategy, policy actors in both case studies provided examples of ways in which they implemented policy in response to local needs. I have already highlighted examples of these innovative actions in early childhood education where culture, language and identity are promoted and encouraged even though these social determinants of Indigenous health are not consistently embedded within policy documents. This is a local level expression of self-determination in policy implementation, but it is far from reframing problematisations in the policy discourse. Bond (2017b) argued that the Australian government is far from implementing decolonising policy because they "listened, acknowledged and then ignored the wishes of Indigenous people to have a say in our own affairs". Following on from this, Bond et al. (2019) argued that national policies, including the CTG strategy are becoming more dysfunctional. They explained that "any new strategy will fail unless it addresses the power imbalances and racism that characterises the current approach to Indigenous policymaking as a whole".

7.7 The expression of power in policy implementation

The representation of Aboriginal people as the problem suggests the presence and influence of power within the CTG strategy. For Foucault (1979), power and power relations are everywhere in a way that multiple forces operate on one another, horizontally and vertically, and within institutions. Power is often analysed through terms of repression or liberation however this fails to embrace greater complexities of power. Others have discussed Foucault's understanding of power as not something to be acquired, seized or shared, but as something that can be resisted in many ways (Baum, 2015; Stone, 2013). Harris et al. (2020) critiqued expressions of power and explained that power is exercised in contexts with moral, legal, political and historical dimensions and can be exercised in ways that are problematic, or empowering and transformative. They presented a glossary of these expressions of power as *power over*, *power with*, *power to*, and *power within,* as shown in Table 11. I have used these definitions to discuss different expressions of power that I observed in this research.

Table 11: Expressions of power (Harris et al., 2020, p. 551)

Table 11: Expressions of power (Harris et al., 2020, p. 551)	
Definitions	Examples from the research
Power over is the best known expression of power. This denotes coercion, and often a win lose relationship. This form of power is associated with domination and results in disempowerment of those whom the power is exerted over.	**Top down power hierarchy** - Rapid roll out of the CTG strategy in SA - Implementation of the IAS
Power with shifts the concept to one of building coalitions and collective strength. Power with is an advocacy oriented concept based on building allies to transform power relations collectively.	**Collective community strength** - Cummeragunja walk off - History of Rumbalara, Lulla's, and the Football and Netball Club - Shepparton murals - "control of the narrative"
Power to is an individualisation whereby each person has the capacity to shape their own world, and opens up the possibilities for power with.	**Acts of self determination** - Exercising choice - Influence of leadership - Role of Champions
Power within emphasises self-worth and self-knowledge, and is the capacity to imagine and have hope – and is a precursor for power to and power with.	***Hope and Resilience*** - Culture as armour

7.7.1 Expressions of *power over*

Power over is associated with domination and disempowerment (Harris et al., 2020). According to Laverack (2009), *power over* describes social relationships where power holders exert control over the actions of others. This power does not have to be expressed through direct force or threat, it can also be expressed through persuasion, economic relations and the distribution of resources. Laverack (2009) explained that *power over* "influences or shapes shared consciousness through the control of information" (p.16). For Foucault (1979), this hegemonic power is embedded within the structure of our every-day lives and often taken for granted. In practice, the power is seen through top-down policy implementation where problem identification comes from a top down hierarchy, defined by an external agent or "expert" (Laverack, 2009). In my research this form of power *over* was divisive in the rapid roll out of the CTG strategy in Southern Adelaide, the way that the Aboriginal positions and services within government departments were cut, and the loss of programs on the ground following the roll out of the IAS. As reported in the results, one participant explained that the structural barriers to policy implementation negatively impacted policy actors because “we lose a lot of passion and drive. They come into this job with the intention, the motivation, the initiative, the passion to want to make this change, but are constrained”.

In Southern Adelaide, one participant offered a very strong analogy of the structure of top-down, *power over* implementation that reflects the dominant role of government exercising *power over* Aboriginal policy actors, people and communities. They explained “like a tree of monkeys, the ones up the top look down and see smiling little faces. The ones down there look up to see arseholes”. In this analogy, power is held over the community who have a very different view of policy implementation from the bottom of the tree. This expression of *power over* established a dominant relationship that was linked to “good intentions” and maintaining the “status quo” of a system that disempowers Aboriginal people. Maintaining a structural status quo reflects a colonial expression of *power over* where certain rules predetermine, guide or constrain policy and implementation (Arts & Van Tatenhove, 2004). One participant explained you are “born into” the power imbalance and that “people in Australia are happy with the status quo”.

An inference from the tree analogy, is that policy actors’ positions in the tree whether at the top, or at the bottom, are determined by race. Moreton-Robinson (2009b) drew on a Foucauldian perspective to define race as a form of power that is used to regulate and defend society from itself (Moreton-Robinson, 2009b). Stone (2013) argued that modern racism can be invisible to the dominant race even though it thrives in health care, health inequity, mortality and education. This explains the view from the top of the tree looking so different to the view from the bottom of the tree. Foucault theorised that in modern society, power is used to maintain control of a dominant race over another (Foucault et al. 2003). For Bond et al. (2019) the racist assumptions that position Indigenous people as “incapable, unruly and in need of management by white institutions continue to inform most government policies”. This was seen in the structure of the IAS where funding recipients would have to earn their autonomy if they met reporting expectations. Moran (2016) explained that policy and implementation in Indigenous affairs reflects an interplay of two systems that are inseparably intertwined. He argued that one system is rooted in Indigenous culture, history and context, and the other system is rooted in conditionality and accountability, resulting in a fractured and complex relationship. I identified in the policy analysis (Chapter 4) that the IAS in particular was an excessive paternalistic structure founded on a deficit approach to working with Aboriginal organisations. Askew et al. (2020) explained that the deficit discourse has preserved colonisation and reproduced inequality. Macoun (2011) agreed that “the problematisation of Aboriginality is a colonial practice, relying on an implied opposition between a problematized Aboriginality and an idealised ‘civilised’ settler order” (p.523). Similarly, Bond (2017c) argued “the settlers have long insisted that our death was destined, that our race was doomed, and that we, as a people, were vanishing. Our disappearance was inevitable because it was necessary to sustain terra nullius, the foundational myth of Australia”. Clearly, expressions of *power over* Aboriginal people are always dependent upon race because “race is inescapable and it has been central to the colonial project” (Bond, 2017a). To ignore race in policy, makes invisible to the dominant majority, the way that race influences the structure of society, institutions and social life.

7.7.2 Expressions of *power with*

Power with is expressed collectively and to show strength (Harris et al., 2020). A collective expression of *power with* is woven into the experience of policy actors in the Shepparton case study. Looking back to the Cummeragunja walk-off, establishing Rumbalara and Lulla’s, and the story behind the Rumbalara Football and Netball club, there is proud history of activism by Aboriginal people in the Shepparton region by which they have asserted their rights. The murals of past champions of Indigenous rights is a visual representation and celebration of *power with.* There remains a commitment to fight for self-determination, described by a participant in Shepparton as a “journey that started 200 plus years ago, and it continues to this day”. My research found that expressions of *power with* have been enacted in Shepparton in a variety of ways during the era of the CTG strategy but not always as a direct act of CTG policy implementation. The collective power is seen in actions to take “control of the narrative” such as using media articles to challenge local racist or deficit-based perceptions and reframe Aboriginal people with a positive lens. *Power with* is also present in Rumbalara’s discussion paper where they challenged the phenomenon of “normalised unwellness” whereby some Aboriginal community members had become accepting of a relatively poor level of health as a normal condition, and were waiting too long to seek help (Rumbalara Aboriginal Cooperative, 2016b). Through the discussion paper, Rumbalara exercises collective power to call attention to “normalised unwellness” as a manifestation of the inequity and injustice of the gap between Aboriginal and non-Indigenous people. Theory on health equity argues that no person should be disadvantaged from achieving their full health potential because of their social position or circumstance (Whitehead & Dahlgren, 2006). In addition, my research has highlighted *power with* as an act of resistance against assimilation in the way that policy actors embedded Indigenous knowledge into education through storytelling, bush kinder, language, and the prioritisation of identity and belonging of Aboriginal children so that children will “feel proud of where they come from”. This expression of *power with* reflects the argument presented in the literature by Smith (2007) that “Indigenous people will never leave their culture to one side; they will not be assimilated” (p.12).

My research showed that when *power with* is focused internally a community gains strength because Aboriginal understandings of health are celebrated and valued. However, when expressed as an act of resistance, *power with* comes up against various expressions of *power over* including the barriers to self-determination. But Bacchi (2009) drew on a Foucauldian perspective to argue that power is most effective when it is hidden. For Foucault, “power is tolerable only on condition that it mask a substantial part of itself. Its success is proportional to its ability to hide its own mechanisms” (Foucault, 1990, p. 89). In this research, I observed collective expressions of power that drew strength internally because as acts of resistance they become a visible act of opposition to *power over* in its many forms. In Southern Adelaide, participants described the burden and fatigue associated with this type of resistance to *power over*. The force of *power over* in a mainstream model of implementation resulted in loss to the workforce, and consequently to the collective nature of *power with.*

The structural constraints on *power with* has meant that advocacy for shaping the CTG agenda does not consistently flow through to implementation. For example, the National Aboriginal and Torres Strait Islander Health Plan and Implementation Plan, was developed with culture at the centre and through a process of working with Aboriginal leaders, and as already noted, the implementation of these policies was never fully funded (Fisher et al., 2018). Fredericks (2011) highlighted that this National Aboriginal and Torres Strait Islander Health Plan is not the first Aboriginal policy to receive incomplete funding as the very first Aboriginal health policy in 1989, with hopes of decolonisation and self-determination, was also never fully funded or implemented. In the same way, the rights-based movement that founded the Close the Gap campaign, drawing attention to health inequity, influenced the agenda setting process that led to the CTG strategy, but the policy documents have not fully recognised Indigenous rights or promoted social determinants of Indigenous health.

The expressions of *power with* through “control of the narrative” or the argument against “normalised unwellness”, exposed some of the wounds of colonisation. The reframing of representations of Aboriginal people as the problem, moving away from the deficit discourse, provided a different narrative highlighting that there is an alternative perspective. However, these expressions of *power with* are disconnected from how policy is written. My research showed that policy actors can influence local level conceptions of Aboriginal people and services but this did not change the structure or content of policy. This reinforced the metaphor of the CTG strategy being a “Bandaid for a bullet wound” because even the positive influence that policy actors have through implementation does not address the underlying, ongoing colonisation and power imbalance embedded in the CTG strategy.

7.7.3 Expressions of *power to*

Power to is expressed by an individual and can lead to collective expressions of *power with*. For Laverack (2009), the simplest form of *power to* is when an individual is able to exercise choice in order to shape their life circumstances. The Shepparton case study showed that choice or control can be exercised when there are options available to individuals for service provision in health and education, so that individuals can choose which kinds of services they use, provided by an Aboriginal controlled service or within the mainstream. But in policy implementation, control was more restricted forcing policy implementation actors to adapt one-size-fits-all national or state strategies to better respond to local need. In Shepparton, individuals within Rumbalara were able to extend the depth of services provided when a community member would attend the medical clinic for a health check, and funds for ear health and blood pressure checks were used to support a more holistic, culturally appropriate approach to assessing service users’ health status.

The comprehensive and holistic approach to health provided through the Aboriginal controlled organisation was not reflected in the mainstream structure of policy implementation in Southern Adelaide. One participant within the health sector explained that the way they had been directed to implement policy meant that services were unable to respond flexibly to the needs of the local community. The lack of choice or control experienced by Aboriginal service providers and community members in the region was amplified due to significant cuts to Aboriginal health programs. The reflection from an Aboriginal participant in Southern Adelaide that they “never felt so marginalised” during the cuts to Aboriginal health revealed the hurt and heartache felt by many participants. With the rapid roll out of the CTG strategy, key processes, key people and key structures were left out which resulted in consultation and policy implementation that did not listen to Aboriginal voices. My analysis using concepts of power indicates that the rapid roll out of the CTG strategy and the cuts to Aboriginal health made by the state health department, not only removed key policy actors and programs from Southern Adelaide, but also marginalised and silenced Aboriginal advocacy which, in effect, removed *power to;* thereby undermining a foundation for *power with.*

For Laverack (2009), an individual's influence on the direction and implementation of policy requires leadership to shift power imbalances. Leadership in policy implementation emerged from the findings as a key factor in moving from *power to* towards *power with*. In Shepparton, the collective and shared approach to leadership was described by one participant as an ecosystem and another participant as a big pie where everyone has a piece. In both analogies, all members of a community have a role to play and leaders facilitate the process in a way that is humble and collaborative. Based on this collective view of leadership from the Aboriginal participants, I identified that in the Shepparton case study, this style of leadership directly influenced the way that policy was implemented under the direction of strong leaders, despite structural and funding limitations. Through Rumbalara, even emerging leaders were supported to draw on their culture and Aboriginal identity as a source of strength. Aboriginal collective culture and approaches to leadership provided a platform for expressions of *power to,* even when Rumbalara was experiencing significant disruptions to executive leadership and management. For example, in Shepparton there were "champions" who expressed *power to* by voicing opinions, making informed decisions, standing up for what they believe in, and taking control of the narrative representing the community in positive ways in local media, and influencing policy implementation. This form of advocacy was seen as an act of self-determination by the research participants.

7.7.4 Expressions of *power within*

Power within is expressed through self-worth, self-knowledge and hope (Harris et al., 2020). In Shepparton, the hope and vision for health equity draws strength from the resilience of previous generations and the prominence of Rumbalara. In Southern Adelaide, there is a vision for greater pride in Aboriginal culture and the recognition of Indigenous knowledge. In both case studies, Aboriginal participants reflected the hope and self-worth of resilience in their descriptions of how communities over time have met adversity and retained cultural identity, expressing *power within* while wrestling with *power over*. In Southern Adelaide, culture was described as a source of armour, essential for survival. Therefore, culture can be both a foundation for health and resilience and a source of protection from domination and disempowerment.

The *power within* from both case studies can be seen as an expression of resilience. Yadeun-Antuñano and Vieira (2020) described resilience as a response to a history of dispossession, displacement, violence and exploitation enforced on Indigenous peoples globally through colonisation. For Indigenous communities, resilience has systemic, collective and communal dimensions (Kirmayer et al., 2011). Cronin, D'arcy, and Murphy (2019) explained that the resilience of Aboriginal and Torres Strait Islander people is more than an individual's ability to adapt, it is grounded in "the strength of tradition and culture, cultural and community relationships, and connection to land" (p.18). In the Southern Adelaide case study results (Chapter 6) I outlined that one participant compared this to being like a "stick in the mud", something for the community to hang on to and even though this "wears and tears" on them, they relied on their culture for strength and purpose. This resilience exists in the face of government policies that have denied Aboriginal people Indigenous rights, premised on assumptions that Aboriginal people were uncivilised, primitive and immoral (Fredericks, 2011). These policies have an ongoing impact on Aboriginal people and communities (Fredericks, 2007, 2008). Fredericks (2011) argued it is "a testament to Aboriginal people's strength and endurance that cultural, social and spiritual practice have survived and continue to be maintained and revived" (p.81).

7.8 Sovereignty has never been ceded

Since colonisation, Australia has been built on a patriarchal white sovereignty even though Aboriginal sovereignty has never been ceded (Moreton-Robinson, 2007). The dominant expression of *power over* has "allowed white colonists to treat Indigenous people as sub-human, enabling them to appropriate Indigenous lands in the name of patriarchal white sovereignty" (Moreton-Robinson, 2007, p. 88). Historical records of Indigenous sovereignty claims have detailed the way that racism is embedded into historical, political and legal issues of sovereignty (Attwood, 2003; Behrendt, 2003; Moreton-Robinson, 2015; Reynolds, 1996). Aboriginal people have been denied the rights and protection generally afforded to Indigenous peoples who have been invaded (Treaty 88 Campaign, 1988). According to Clayton-Dixon (2015), sovereignty is a foundation of all rights for Aboriginal people, including self-determination. He argued that Aboriginal sovereignty is rooted in connection to county, culture, and family. He wrote "our sovereignty has endured since the first sunrise and it's the vision for Aboriginal people to take our place among the nations and peoples of the world, not beneath them". The dominance of a colonial expression of *power over*, has precluded the recognition of Indigenous sovereignty (Moreton-Robinson, 2006). Clayton-Dixon (2015) identified assimilation as a threat to Indigenous sovereignty but the resistance to assimilation is unrelenting (Smith, 2007).

There have been many significant moments in history where expressions of *power with, power to* and *power within* have pushed back against the colonial *power over* Aboriginal people. Towards the end of the CTG strategy decade, in 2017, the Referendum Council, a body appointed by the Australian Prime Minster and Leader of the Opposition to provide advice on constitutional reform for the recognition of Aboriginal and Torres Strait Islander people within the constitution (Hobbs, 2017a), collated a series of dialogues and responses which fed into the Uluru Convention. The resulting 'Uluru Statement From The Heart' called for voice, treaty and truth, asserting Indigenous rights to an ongoing voice in Australian policy (Appleby & McKinnon, 2017). Within the Uluru Statement, the Referendum Council sought "a Makarrata Commission to supervise a process of agreement-making between governments and First Nations and truth-telling about our history" (Referendum Council, 2017). Appleby and McKinnon (2017) explained that Makarrata means coming together after a struggle, which echoes long held aspirations of Aboriginal and Torres Strait Islander people for a treaty, to achieve self-determination. However, this opportunity for the Australian government to support and value the contribution of the Referendum Council and lengthy consultation with Aboriginal and Torres Strait Islander people, was denied. The Australian government rejected the call for a national Indigenous representative voice to parliament on the basis that they believed such a radical proposal was not supported by the majority of Australians, that it was unclear how the voice to parliament would work, and that it would inevitably become a problematic third chamber of parliament (Hobbs, 2017b) . Gordon (2017) described the rejection of the Uluru Statement From The Heart as a very cruel political calculation. Hobbs (2017b) argued "Indigenous people were asked directly what recognition meant to them. They have responded, and the government has dismissed their views". In addition, the Prime Minister at that time argued that Aboriginal and

Torres Strait Islander people already have a voice in government through elected members of parliament. This was criticised as another push for mainstreaming or assimilation, rather than a recognition of Indigenous rights (Chang, 2017). This example demonstrates the dominance of *power over* to reject the 'Uluru Statement From The Heart' with little consequence. The rejection maintains *power over* and the patriarchal white sovereignty that is described as a regime of power, born from the illegal act of possession (Moreton-Robinson, 2015). Moreton-Robinson (2007) wrote "As a regime of power, patriarchal white sovereignty operates ideologically, materially and discursively to reproduce and maintain its investment in the nation as a white possession" (p.88). Bond (2017b) highlighted that despite the initial public outcry at the dismissal of the Uluru Statement, most Australians have moved on, accepting the dominance of the power holders. Bond et al. (2019) argued that "unless the evaluation process examines the government's shortcomings, as well as the ingrained, racially driven assumptions about the inability of Indigenous peoples to manage their own affairs, it will fail to bring any necessary improvements to Indigenous policymaking".

Drawing on the results of my policy analysis, a recognition of Indigenous sovereignty is what is missing to shift patriarchal colonial power and prioritise decolonisation, self-determination and a recognition of Indigenous rights. In addition, the case study results showed that the influence of local policy actors on implementation is not enough to address the underlying wounds of colonisation. The diverse nature of Aboriginal and Torres Strait Islander peoples across Australia means that diverse actions are essential in policy implementation but there should be a way for the innovative responses to policy to go back up the chain to the policy makers. The results of this research showed that this feedback is not heard by policy makers due to poor or non-existent consultation. In the tree analogy from Southern Adelaide, those at the bottom of the tree have smiling faces but they keeping looking up to "see arseholes" and their voice and experience is not acknowledged. Despite the limitations of policy and colonial power structures, Indigenous rights and decolonisation are being pursued by communities in differing ways depending on their circumstances. Ultimately this is because sovereignty has never been ceded. Therefore, services in the mainstream ensure that targeted programs like connecting with Elders at Taikurrendi or providing a bus service to Aboriginal families at Christie Downs Kindergarten remain a priority due to the influence of strong leaders. But the evidence from this research showed that Aboriginal community-controlled organisations like Rumbalara or Lulla's were crucial in providing appropriate services and shifting the locus of control over policy implementation. For example, at Lulla's the right to an Aboriginal childhood was enacted through activities where culture, identity and belonging were nurtured and celebrated, but also normalised and expected. In Southern Adelaide, an Aboriginal childhood was valued and respected but not positioned as an Indigenous right in the same ways as seen in Shepparton where there is collective expression of power with, through the influence of services for Aboriginal people by Aboriginal people. Therefore, even though the policy analysis showed that the concept of an Aboriginal childhood is absent from policy, participants from the Shepparton case study promoted this as an Indigenous right, "they have to be an Aboriginal child. That's a given". I argue that my research has shown that Aboriginal controlled services are in the best position to implement locally focused policy in ways that recognise and act on Indigenous rights, including the right to an Aboriginal childhood. The analysis of the two case studies showed that where there is an Aboriginal controlled organisation, policy is implemented in ways that more consistently align with promoting the right to social determinants of Indigenous health and self-determination. Importantly, decolonisation cannot be fully realised until the problem representation and deficit discourse is removed from the overarching strategy. Given that we are not on track to meet the targets on closing the gap in health inequity in Australia, Indigenous rights, social determinants of Indigenous health, self-determination and decolonisation require greater attention and action within the next era of the CTG strategy.

7.9 Limitations of the study

While every effort has been made to ensure the quality of this research there are limitations to note. Firstly, living in Southern Adelaide allowed me to participate more regularly with the community and develop a deeper understanding of the policy implementation context. While I visited Shepparton five times during the study, the depth of my engagement was less. My participation with the community in Shepparton was by invitation and although I felt warmly welcomed to the region, I am of course more comfortable in my own local space. During data collection, I had to ask more probing questions in Shepparton as I did not have the same level of assumed knowledge of places, events and people when compared to Southern Adelaide. For example, I had a much clearer understanding of the impact of cuts to Aboriginal health services in Southern Adelaide as I knew the impact on local families who are my friends and neighbours. In Shepparton, during my PhD there were multiple leadership changes at the senior level within Rumbalara but this was not raised by participants in interviews so I cannot expand on this nor fully understand the impact (if any) on the community. Throughout data analysis I had to trust the data explicitly in Shepparton whereas I could “read between the lines” and interpret meaning more readily when analysing data from Southern Adelaide. In order to protect the integrity of the data, the partnership with Rumbalara was essential as I sought feedback initially on the interview guide from the Associate Researcher, and then throughout the research as we analysed data and discussed key themes during workshops.

It is important to note that not every policy actor within the CTG strategy early childhood context responded to the invitation or participated in the study. Due to the feasibility and exclusion criteria, we did not explore the perspective of policy actors within child protection services. This is because child protection is outside of the remit of the first decade of CTG policy. As the issue of child removals was raised by participants, I explored this as theme within the data in regard to the implications for the CTG strategy.

As a non-Indigenous researcher, I acknowledge that distrust between Aboriginal communities and researchers is a protective factor in response to generations of racism and discrimination. While I have positioned this research at the interface of knowledge and ensured reflexivity throughout, I cannot deny that my ethnicity may be a limitation to the research.

7.10 Chapter Summary

In this Chapter I have discussed the way that Indigenous rights are prioritised and acted on in different ways through the implementation of the CTG strategy. Indigenous rights can be named and recognised, implied, or undermined and ignored. Even when social determinants of Indigenous health are included in policy documents, implementation of policy that prioritises culture, identity, and belonging is often dependent upon the influence of leaders at the local level. The implementation of policy can bend to meet local need even when structures in health and education act to limit self-determination. There are many examples of tokenistic approaches to consultation in way that the CTG strategy has been implemented where the rhetoric of “working with” Aboriginal people and communities did not shift power imbalances. The underlying assumptions within policy frame Aboriginal childhood through a biomedical and developmental lens rather than with an Aboriginal understanding of health, which influences the way that early childhood education services are structured. In addition, the problematisation of Aboriginal people serves to maintain power over and limit power with and power to. However, Indigenous sovereignty has never been ceded and therefore power within provides a source of hope, strength and resilience for Aboriginal people and communities.

CHAPTER 8: CONCLUSION

In my research the CTG strategy was described as a "Bandaid for a bullet wound" suggesting that policy implementation could not heal the underlying wounds of colonisation and causes of health inequity. In some cases, the policies undermined Indigenous rights when implementation was pushed into mainstream service provision which cannot recognise and act on Indigenous rights and social determinants of Indigenous health to the same extent as can be achieved through Aboriginal controlled organisations. Despite the influence of local policy actors who promoted culture and self-determination to some extent, the deficit discourse and representation of Aboriginal people as a problem remains prominent in policy. To conclude this thesis, I discuss the implications for policy implementation and advocate for moving beyond the rhetoric of "working with" Aboriginal people towards self-determination. I position this discussion in relation to progress for the next iteration of the CTG strategy and I highlight the importance of Aboriginal community-controlled organisations in early childhood

8.1 Implications for policy implementation

By the end of this research project, the CTG strategy was under revision following a statement calling for a "CTG refresh". In this statement, the Council of Australian Governments (COAG) recognised the importance of partnership with Aboriginal and Torres Strait Islander people and communities in the design and implementation of policy, in order to effect change (Council of Australia Governments, 2018). Proposed actions within the refresh include a revision of CTG targets and the National Indigenous Reform Agreement, and to work collaboratively with Aboriginal and Torres-Strait Islander key stakeholders. One outcome from the planned refresh is a CTG Partnership Agreement (Council of Australia Governments, 2019) to recognise the importance of shared decision making for the design, implementation and monitoring of the CTG strategy. In this partnership agreement, The Coalition of Peaks was formed, with members from Aboriginal and Torres Strait Islander bodies to represent communities, to partner with COAG in the development and implementation of the CTG strategy, share ownership and responsibility for progress, to enhance credibility and public support for CTG in the next decade, and to “advance Aboriginal and Torres Strait Islander involvement, engagement and autonomy through equitable participation, share authority and decision making in relation to Closing the Gap” (Council of Australia Governments, 2019, p. 4).

From my research, I have identified eight implications for policy and implementation for the next era of the CTG strategy that can move policy beyond Bandaid solutions and begin to heal the underlying wounds of colonisation, as shown in Table 12. The recommendations from my research support principles and processes of engagement outlined by the Coalition of Peaks (2020) to reform policy, increase transparency and ensure that governments listen to Aboriginal and Torres Strait Islander people.

Table 12: Implications for policy implementation

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1. Decolonise policy implementation structures
2. Recognise and act on Indigenous rights
3. Promote and fund Aboriginal controlled organisations
4. Recognise, honour and celebrate the champions
5. Move beyond the rhetoric and build trust
6. Challenge the framing of Aboriginal childhood
7. Decolonise problem representation
8. Acknowledge sovereignty

8.1.1 Decolonise policy implementation structures

The rapid roll out of the CTG strategy, the burden of over-reporting and monitoring of Aboriginal organisations, the short-term funding models, and the issues identified in consultation processes reveal the need for reform in policy implementation structures and processes. Decolonising policy implementation would shift these structures and processes toward a strengths-based approach where culture and Indigenous knowledge are valued and respected. Stable national, state and local partnerships should inform policy development and implementation. The insecure, short-term, prescriptive and fragmented funding that have been prominent features of the CTG strategy must be discontinued. Long term funding for community-controlled services and other services at the local level in health and education is essential to ensure that policy is implemented in ways that respond to local needs and improve health of children, families and communities.

8.1.2 Recognise and act on Indigenous rights

In order to close the gap in health inequity, policy must recognise and act on Indigenous rights and social determinants of Indigenous health. New policies within the CTG strategy must not undermine self-determination. Policies such as the National Aboriginal and Torres Strat Islander Health Plan that prioritise culture must be fully funded and implemented. Funding for the implementation of the CTG strategy must target Aboriginal children, families and communities and not be solely shifted into mainstream programs with universal access. Accountability for the implementation of equity-focused policy could then consistently promote Indigenous rights, as well as human rights. The Coalition of Peaks (2020) argued that mainstream organisations must be held publicly accountable and do much more to improve the health of Aboriginal and Torres Strait Islander people and communities. This includes tackling systemic racism, promoting cultural safety and transferring power and resources to communities and Aboriginal controlled organisations so that Aboriginal and Torres Strait Islander people have influence over decision making.

8.1.3 Promote and fund Aboriginal controlled organisations

Aboriginal controlled organisations are in the best position to implemented CTG policy for Aboriginal people, by Aboriginal people. These organisations have the knowledge, relationships and respect from community to work in appropriate and safe ways that respond to local need. Empowering Aboriginal controlled organisations with funding and flexibility in implementation would shift power and promote self-determination. Governments at federal, state and local level must trust Aboriginal leaders who know what they are doing, know their communities, and will work from an Aboriginal view of health and well-being. The Coalition of Peaks (2020) identified maternal and child health, education, family services and child and youth services (among others) as sectors that require strengthening through community control.

8.1.4 Recognise, honour and celebrate the champions

There are generations of Aboriginal leaders within communities who have fought for Indigenous rights and self-determination. Communities draw strength from the champions and their commitment to advocacy and activism must be recognised, honoured and celebrated. Communities will know how to appropriately commemorate the achievements of their leaders, whether that be a public mural or a quiet reflection. Acknowledging the collective resilience of Aboriginal people fosters hope for equity and equality.

8.1.5 Move beyond the rhetoric and build trust

After identifying the tokenistic approaches to consultation and policy implementation, the next era of the CTG strategy must move beyond the rhetoric of "working with" Aboriginal people and communities and build trust between governments, policy actors, implementers and community. Key stakeholders have to keep "really listening" to one another, with the intent to learn and respond. Without true partnerships that are mutually beneficial, the next era of the CTG strategy runs the risk of writing partnerships into policy documents that are not enacted as planned. Reciprocity is essential if partnerships are to be successful. This requires a sharing of power, responsibility and ownership of policy actions. The Coalition of Peaks (2020) report provides an example of an engagement process and benchmark for participation and self-determination that should serve as a guide for future policy consultation and implementation.

8.1.6 Challenge the framing of Aboriginal childhood

In the next era of the CTG strategy, there is an opportunity to reconsider the way that an Aboriginal childhood is framed within the context of a biomedical, developmental understanding of childhood. If an Aboriginal view of health becomes the centre of CTG policy, then strategies are more likely to support rights to an Aboriginal childhood. This could include the prioritisation of culture, language, identity and belonging for Aboriginal children as a norm, rather than an optional or additional program. Growing up strong in culture must be embedded as a foundation for the CTG strategy in early childhood. Refocusing the narrative on the strengths of an Aboriginal childhood shifts the narrative away from the deficit discourse and focus on risk factors for child removal.

8.1.7 Decolonise problem representation

The representation of Aboriginal people as the problem reinforces a Bandaid approach to policy and this must be challenged. In early childhood, the increasing numbers of Aboriginal children in out of home care shows that the underlying problem has not been addressed through the CTG strategy to date. Decolonising the problem representations within the CTG strategy will shift the focus to the underlying trauma and ongoing impact of colonisation on children, families and communities. CTG targets for the next era of the CTG strategy must extend beyond enrolment and attendance at kindergarten to the accessibility and cultural safety of early childhood services. The targets of the CTG strategy are all inter-connected in the way that children live within families and therefore policies on employment and housing will also impact on the health and well-being of children. Therefore, a decolonising approach to improving all of the CTG strategy targets will amplify Indigenous rights and social determinants of Indigenous health across sectors and throughout communities.

8.1.8 Acknowledge sovereignty

Indigenous rights in Australia cannot be fully recognised or enacted without acknowledging that sovereignty has never been ceded. The CTG strategy must continue to promote human rights related to education and health but ignoring Indigenous rights undermines progress towards equity. With a new era of the CTG strategy, there is an opportunity to once again call out the dispossession, marginalisation and discrimination of Aboriginal and Torres Strait Islander people and recognise Indigenous sovereignty. The rejection by the Australian government of the 'Uluru Statement From The Heart' reminds us that government *power over* Aboriginal people will act to quiet advocacy and reinforce the status quo. Therefore, the CTG strategy must provide opportunities and structures for expressions of *power with*, *power to* and *power within* to speak out against ongoing colonisation and promote the recognition of Indigenous rights.

8.2 Concluding comment

In summary, this thesis contributes new knowledge on the implementation of the CTG strategy in early childhood. The policy analysis revealed the inconsistent recognition of the Indigenous rights and the case studies showed the different ways that social determinants of Indigenous health are recognised and acted on through implementation. The synthesis of these results showed that despite local influence over policy implementation, the deficit discourse, colonial power structures and problem representations remain. The implications for policy from this research promote decolonisation of the CTG strategy. Such a shift in power, engagement and control has the potential to move the CTG strategy beyond a "Bandaid for a bullet wound" towards policy that recognises Indigenous rights, and promotes social determinants of Indigenous health and health equity.

CHAPTER 9: REFLECTION

My reflection is founded upon the recognition that colonisation has, and continues to exclude Aboriginal ways of knowing, being and doing (Sherwood et al., 2015). The decolonising methodology in this research required me to explore policy, history and knowledge from an Indigenous perspective and to consider how this should inform political and social action. As I have embedded principles of respect, reciprocity and self-awareness in my research, I have learned and unlearned more than I could have expected. In this Chapter I reflect on decolonising methodology, and my journey as a non-Indigenous researcher. I begin by explaining my standpoint and then move on to outline my transformational unlearning. I discuss examples of peer mentoring, deep listening and how I drew on my experience as an occupational therapist for community engagement. I Identify some of the challenges I experienced conducting research at the interface of knowledge and finally reflect on the importance of honouring was has been shared.

8.1 Who was I?

At the beginning my PhD journey I described myself as a culturally aware and respectful occupational therapist with a heart for social justice and research. My work experience was in primary health care, working mostly with children and families. I had worked for many years overseas, practiced in languages other than English, and felt very comfortable working cross-culturally. I was confident, assertive and ready for the challenge of research in an Indigenous space. This was not my first experience working with Aboriginal and Torres Strait Islander people and communities. I had taught Aboriginal students at university and worked alongside Aboriginal health professionals. I quickly learned that it is one thing to academically understand decolonisation, it is another to be doing it and learning from it and I embarked on a journey of transformational unlearning.

8.2 Who am I?

I am the 5th generation of my family born in Australia. My father's Germanic family came to Australia from Prussia, seeking a better life, and freedom from religious persecution. Johann Blesing and Anna Schaenshcer travelled with their first three children to South Australia on the Skjold in 1841. They had five more children in Australia. Anna died in 1854 and Johan then married Juliana Will. Together with sixth born son Ernst, his wife Elizabeth Flower and their families, the Blesings settled in the Southern Flinders Ranges on a farm called Glenholme, officially in 1893. Ernst, Elizabeth and their children cleared the land using horses and manual labour. The original homestead is lovingly called the "old garden" and although now a ruin, is still treasured by my father and his siblings.

My Great Grandfather, (son of Ernst) Albert Percy Blesing, is an interesting character to me, described by my father as "larger than life", and a "bit of a larakin". Tilby-Stock (1993) described him as "dark haired, tall and robust, and sported a bushy moustache as a young man". With an interest in politics, he was a founding member of the Country Party and elected to the South Australian state government in 1924. He served his community in public office for two decades and held six portfolios. With only a grade 7 level education, he battled against the much more highly educated politicians elected at that time. He became the South Australian Minister for Agriculture (under the Playford government) in 1933. One story I heard from my father about my great grandfather's leadership was when there was an issue with the fisheries in his electorate. He took the opposition shadow minister in his old Buick to the local country town, sent his opponent into the Labour pub, and he went into the Country Party pub. There they informed locals that they had to shut the fisheries for a season. I like to think that he represented the interests of his electorate first and foremost and therefore this kind of bipartisan approach to connecting with community seems logical. Tilby-Stock (1993) described him as a stubborn advocate for his constituents and during his time in government, he fought for rural rehabilitation, agricultural education and the expansion of the Port Lincoln freezing works. Albert Percy served as the Minister for Agriculture until a falling out with his good friend Playford in 1944 (State Library of South Australia, 1993). He was better known as the "Minister for Billiards" and throughout his political career, was jovial, enjoyed a day at the races, and continued to play bowls and golf (Tilby-Stock, 1993). I'm told that he loved the billiard table in parliament house so much that he took the billiard table home with him to Glenholme. Albert Percy held his seat in government until his death in 1949 following a gall-bladder operation. As reported in The Advertiser (1949), he was accorded a state funeral and survived by his wife, two daughters and two sons, one of whom was my grandfather.

Learning about my family history gives me a deep sense of belonging and identity. As I uncover the characters in my family I wonder what influence they have had, and continue to have on me. How much of my interest in policy comes from a connection to a heritage that I really know very little about? And with regard to the traditional owners of the lands, I wonder how my family might have interacted with Aboriginal people? They are questions that remain unanswered.

Glenholme is located on the traditional lands of the Nukunu people. I have not found any record of interaction between Aboriginal custodians of the land and my family. I suspect that Aboriginal people had been moved off the land to the towns of Port Augusta, Port Germaine, Crystal Brooke, or Laura prior to settlement. My father told me there is no evidence of Aboriginal people living on the farm land that we know of, but I find it hard to believe that Nukunu people would not have lived there. My family established a beautiful orchard in a small valley, with a running stream, protected from the wind. The ground was fertile and the scenery is still breathtaking. There is a natural waterfall nearby and I have fond childhood memories of jumping over rocks in order to find the water, it felt like an adventure. I imagine that all of the reasons my family established their home in this place, are all the same reason why Aboriginal people would have been there before them.

I live with my family in Southern Adelaide, on the land of the Kaurna people. I have studied public health and taught primary health care and social determinants of health to the next generation of allied health professionals at three universities. As an occupational therapist, I am passionate about the importance of occupation, that is, any activity that brings purpose and meaning, to health and well-being. I love to teach and challenge students to see health outside the medical model, and become aware of the health inequities in society. In 2018, I attended the World Federation of Occupational Therapists Congress in South Africa and at the opening ceremony, disability advocate Marline Le Roux stated that “to be an occupational therapist is to be an activist” (World Federation of Occupational Therapists, 2018). I realised that as a researcher in public health, I could connect my professional knowledge and heart for occupation with my research on health inequity to highlight the issues in implementation that I had analysed in the CTG strategy. “To be an activist” implies a power struggle where *power to*, *with* and *within* can resist *power over* (as described in Chapter 7). Therefore, what I have learned about power strengthens my resolve to be an activist as an occupational therapist.

8.3 Reflecting on research at the interface of knowledge

As established in Chapter 3, decolonisation is not necessarily a rejection of colonialism, rather it seeks to reimagine and rearticulate power, change and knowledge, as it questions and resists colonial relations of power that threaten Indigenous ways of being (Sium et al., 2012). Therefore, I was mindful of what Sherwood (2009) and Muller (2014) wrote about embracing a decolonising approach to research in Australia, to realise the impact of colonisation and how this can inform political and social action on issues of Indigenous rights. I realised that if I was to conduct decolonising research, my reflection must not only consider my role as a non-Indigenous researcher (Gray & Oprescue, 2016), but also the way that Indigenous knowledge can and must be embedded in methodology.

I used questions presented by Wilson (2014) to recognise the limitations in my thinking and to challenge myself to reflect on the research process as well as the findings. Wilson’s model for reflexive practice guides a researcher through stages to explore challenges, learnings, new levels of understanding, and then change in practice. Each stage includes questions which allowed me to explore what I thought, felt and why I responded to experiences and information in certain ways, summarised in Table 13.

Table 13: Questions to Assist Researchers to be Reflexive in their practice in Aboriginal and Torres Strait Islander Health (Wilson, 2014, p. 227)

Table 13: Questions to Assist Researchers to be Reflexive in their practice in Aboriginal and Torres Strait Islander Health (Wilson, 2014, p. 227)	
Stage	Questions
Challenges	What was the experience? What happened? How did it make you feel? What did you (or didn't you do) as a result of these feelings? If you feel discomfort, what made you uncomfortable? Why?
Learnings	What happened this time? How did it make you feel? What did (or didn't you do) as a result of these feelings? Is this the same or different to last time? What did you learn from last time? Did this affect the way that you reacted this time? Why or why not? What did you learn?
New levels of understanding	What new levels of understanding did you reach? Based on your learnings? What do you now understand that you didn't before?
Change in practice	How did this change your practice? Are you doing anything differently now? Why or why not? What feelings do you experience in similar situations? Are they similar or different to the first time?

In the first year of my PhD, I had assumed that because the intent to close the gap in health inequity was so important, that the CTG strategy would be widely accepted. I was shocked to learn that the CTG strategy was not viewed in a positive light by everyone. This made me feel uncomfortable because what I learned about the deficit discourse in the CTG strategy was unexpected for me. As I worked through the policy documents I became more frustrated with the way that rights were not consistently recognised and even undermined. I learned to look deeper at assumptions and problem representations. I reached a new level of understanding when I connected the way that rights are recognised within the policy documents with the way that policy is implemented through mainstream, targeted and community-controlled approaches. This was evidence of a deeper understanding of the structure of policy and implementation, and the colonising dynamic present within the CTG strategy and implementation.

In Chapter 3, I explained that this research at the interface of knowledge draws on principles of mutual respect, shared benefits, human dignity and discovery (Durie, 2005). In the visual representation of this model by Ryder et al. (2019) different knowledges are shown to be woven together. But for me, the weaving of knowledge was not simple. In order to weave in new ways of thinking, to prioritise decolonising methodology and Indigenous knowledge, I had to first unravel some of my pre-existing ideas about research methods, the CTG strategy itself and self-determination. At the start of my PhD, I didn't see the hidden assumptions of deficit framing and *power over* in the CTG strategy as clearly as I do now.

I had to unravel myself from dominant ways of thinking, so that I could sit in the interface of knowledge and weave different ways of knowing, being and doing into the research. This meant I could understand the inequality in the statistics of child removals, the measuring of targets in the CTG strategy, and the protective factors associated with mainstreaming health and education, while also analysing problem representation, power and Indigenous sovereignty. The unravelling and weaving of knowledges was a dynamic process for me and not easily bound by the structure or timing of a PhD candidature. This means that I will continue to need to unravel and weave with the support of Aboriginal colleagues as I am committed to practices of decolonisation in research and in occupational therapy.

8.4 Transformational unlearning

I describe this process of unravelling and weaving as transformational unlearning. The more I learn about Indigenous knowledge and decolonisation, I become more aware of whiteness and unconscious bias. In the first year of my PhD, an Indigenous advocate told me that "if you are born into white Australia, and you're not racist, you're a miracle". This comment made me see more clearly than ever before, that my position in society is a position of privilege. Therefore, it is impossible to not be influenced by world views that reflect the dominant, white patriarchal and racist society in which I live. This sat heavily on me for many months. My Indigenous colleagues at the time encouraged me not to be too hard on myself. The challenge was set to shift my world view, and unravel, so that I was more open to learn from, to respect, and to value Indigenous knowledge. I wrestled with my discomfort in this unravelling process as my mind shifted to see injustice and systemic racism more clearly. I realised that takes time and painful reflection for both sides of colonisation to become visible to those in the dominant culture, the power holders.

As I analysed the findings from the research I reflected on the way that white cultural dominance shapes our lives and is the standard by which differences from the norm are measured and judged (Moreton-Robinson, 2009b). Like power, white privilege is easily ignored or even invisible (Durey, 2015). For example, I do not have to face the struggles of my Aboriginal friends and colleagues. I can even choose to ignore racist slurs, because they are never said about me. However, many studies have shown that if left unacknowledged, this white privilege can perpetuate discrimination and health inequity (Durey et al. 2014; Larson, Coffin, Gilles, & Howard, 2007).

8.4.1 Importance of peer mentoring

I could not have managed to unravel and unlearn without the support of Aboriginal colleagues. As outlined in Chapter 3, during my PhD I met regularly with an Aboriginal mentor to discuss what I was learning and unlearning. Our “yarns” were informal from a scientific perspective, and essential from an Indigenous perspective. Taking time to slow down my thinking helped me to understand why I was frustrated with the lack of recognitions of rights in the Indigenous Advancement Strategy, angry about the cuts to Aboriginal health, or devastated by the community conflict over unmet expectations of the CTG strategy. As I sat at the interface of these complex factors impacting policy implementation, it was appropriate to be frustrated, angry and devastated. If I had shut myself off from the injustice of how Indigenous rights are not fully recognised or acted on in the CTG strategy, then I would not have been able to fully respect or value an Indigenous perspective on the CTG strategy. If I avoided the discussion on power and how colonisation is ongoing, then I would be complicit in the injustice. If I ignored that sovereignty has never been ceded, then I miss how the CTG strategy and its implementation, is an example of a representing Aboriginal people as a problem to be fixed, as policy subjects, and less than others. The opportunity to debrief regularly throughout my PhD with a peer mentor has been invaluable to my research.

8.4.2 Deep listening for reflection

In both case studies I learned to slow down my thinking, spend time on country and to listen. In Chapter 3, I described deep listening as process for reflexivity and to explore complex concepts (Atkinson, 2002; West et al., 2012). As an occupational therapist I drew on my understanding of the practice of mindfulness as a way to conduct deep listening, and unravel rigid thinking to be more open to new knowledge. Mindfulness is a “flexible state of mind where we are actively engaged in the present, noticing new things and sensitive to context" (Langer, 2000, p. 220), and a way of tuning in to what is happening in and around us (Schoeberlein & Sheth, 2009). Scaffa (2019) explained that mindfulness facilitates an awareness of an emotional state without judgement. In practice, using mindfulness techniques that were familiar to me as an occupational therapist facilitated deep listening so that I could pay closer attention to the environment, the sunlight, the wind in the trees, the crunch of leaves under my feet, the movement of water, and birds singing, and the stillness of my own body while I contemplated what I was learning in the research.

For example, in Southern Adelaide, at the end of 2019, together with the Joining Hands and Minds network I visited the Aldinga washpool with Elder, Aunty Georgina Williams to learn more about the significance of the site as part of the Tjilbruke story, the history of dispossession and the advocacy required to protect significant sites from urban development and vandalism. Aunty Georgina explained the importance of the stones at this beach which were used in tailoring animal skins. She uses these stones every time she offers a Welcome to Country and she invited the 14 people in attendance to hold the stones in their hands. Together, workers from mental health services, the homelessness sector, child protection, early childhood services, and more took time to quietly reflect on the importance of honouring Aboriginal culture and history in Southern Adelaide. My tactile connection with the stones facilitated deep listening, to help me feel Aunty Georgina's words on a deeper level. Holding stones in my hands became an act of mindfulness as I paid attention to the coolness of the stone and the smooth texture (shown in Figure 15). I became more aware of the sound of the ocean the wind on my skin. As I paid attention to the rich sensory input at that moment, I was able to focus my thoughts on the wise words of Aunty Georgina as she shared her pain and frustration at the ongoing battle for the recognition of Indigenous rights, the protection of land and sacred sites, and the importance of sharing knowledge.

Figure 15: The Aldinga Rock Pools, Southern Adelaide case study (Photos by Emma George)

In the Shepparton case study results (Chapter 6) I described the Mooroopna Aboriginal Historical Walk where visitors can learn about the Cummeragunja walk off, life on the flats and the origin of Rumbalara. Completing the walk with a staff member from Rumbalara and my Aboriginal PhD Supervisor was a key moment for reflection in my research journey. Not only did I learn about the history of Rumbalara, but I also gained insight what life had been like for Aboriginal people, and the legacy they carry with them. This guided walk allowed me to reflect on the resilience and determination shown by generations of leaders in Shepparton. Walking through the gum trees, stopping in the meeting places, listening to the sound of the river, and the wind in the trees, has enhanced my understanding of this place. Then when participants told me about activism, advocacy and leadership in Shepparton, I had a deeper appreciation for what they meant.

I took a photo near the start of the walking trail where the path is bordered by the highway to the left, and the river to the right, as shown in Figure 16. Initially it felt like the natural beauty of the river and the cold impression of the road were incompatible. I printed out this photo and sat it on my desk. It became a symbol of where I stood in the research, wondering how I could integrate knowledges. The separation of the river and the highway represented the challenge of research at the interface of knowledges.

Figure 16: Path between the highway and the river, Shepparton case study (Photo by Emma George)

But as I unravelled and wove in new ideas and understanding into my own research journey, my perspective on the image changed to show how close these knowledges can be when we facilitate weaving at the interface. I have learned that weaving takes patience, time, intentional mindfulness or deep listening, and a commitment to mutual respect, responsibility and reciprocity (Durie, 2005; Hart, 2010; Sherwood, 2010).

8.4.3 Occupation in decolonising methodology

As an occupational therapist, I understand that occupation is any activity we do in our lives that has meaning and purpose. Occupational is all of the things that people do from the everyday to the extraordinary and engaging in meaningful occupation is essential for health and well-being (Wilcock, 1999, 2006; Wilcock & Hocking, 2015). In the field of occupational science, a prominent theory by Wilcock (2006) is that doing, being, becoming and belonging are essential for survival and health. Therefore, is it not just the practice of doing an occupation that has meaning, but also the way that occupation builds identity, belonging and growth to support health and well-being of individuals and communities. I could not unravel my thinking from this occupational perspective of health. Therefore, I embraced the way that I think as an occupational therapist and embedded occupation in decolonising methodology, ensuring that I did things with people in a way that I could pay respect to Indigenous knowledge and engage in acts of reciprocity.

Netball is my happy place. It is a sport I have played and coached for many years. Growing up in South East Asia I played at an international level, and a state league level in South Australia. I was delighted to learn about the Rumbalara Football and Netball Club in Shepparton and thrilled to be invited to training. In Chapter 3 I described the impact that participating in netball had on building rapport with community and interest in my research. I went to Rumbalara netball training for the first time in 2017 because I love netball and I knew building relationships with community would help me understand the Shepparton context. I visited the netball club again in 2018 and 2019 and was able to donate some training equipment. After the final session, I received messages expressing thanks from research participants who I hadn't been able to see in person, but their daughters had been at training. It was encouraging to hear back from community and know that the training I ran for the community had benefit. Initially I thought that that my simple contribution to the netball club probably had more benefit for me as I was able to do something I love, fulfil my desire to connect with people, and promote my research. But my mentor and supervisors reminded me that reciprocity in a decolonising approach to research isn't about giving and taking, it's about giving and giving. Reciprocity is an exchange described as "ngapartji ngapartji" built upon mutual respect. Therefore, I am thankful for the opportunity to offer something of benefit to young netballers in a community that welcomed me and shared their netball court, their time, and their knowledge with me. I trust that in a spirit of "ngapartji ngapartji", my acts of service also had benefit for them.

8.5 Challenges of research at the interface of knowledge

In Chapter 3, I outlined that decolonising approaches to research are uncommon in Australian universities as decolonisation requires power shifting and valuing Indigenous knowledge. In this research, I faced a number of challenges to embedding Indigenous knowledge and adopting decolonising methodology. These challenges reflect the prioritisation of deadlines, milestones and to complete the research project within a structured higher education system. I have categorised these challenges into concepts of time, process, analysis and writing.

8.5.1 Time

When I began my PhD on a full-time scholarship, I was well aware of the time allowed for me to complete the research according to university policy. There is increasing pressure on students to complete their PhD within three years. I knew immediately that it would be inappropriate for me to push the research onto communities in the case studies. I did not want to rush the process of building relationships and establishing a foundation based on respect and reciprocity. Yalmambirra (2000) explained that time is understood very differently through a western and Indigenous perspective. He described "white time" as focused on the calendar and the clock where there is a time to go to sleep, to get up, to go to work, for dinner, for sport. However Indigenous time began with the era of creation and is centred on seasonal movements, traditional practices, resources, the environment and people. Yalmambirra (2000) presents the contrast in understandings of “black time” and “white time” which is very difficult to weave together. To some extent, I was challenged by this contrast as I was pressured by the higher education system and my own ambition, to conduct my PhD in a “timely” fashion, while also allowing time to respond to community, participate in events in Southern Adelaide, visit Shepparton and connect with people. Therefore, I mapped my time week by week in the first two years of my research to ensure I could meet all milestones while I intentionally saved space for community, unlearning and learning. I tried to be both structured and unstructured. When I reduced my study load to part time, my time became even more structured as I was balancing a university teaching work load in addition to PhD. It became more difficult to be flexible because I had to fit research around teaching commitments. This makes me wonder if conducting decolonising research under time pressure may limit the depth of a project.

8.5.2 The research process

In Chapter 7 I discussed the limitations of the research and recognised the challenge of living in one case study and travelling to visit another. Although I am confident that the process of conducting research in the two case studies met appropriate standards of quality, the experience of conducting research in these different locations was challenging. I always felt like an outsider in Shepparton even though I was warmly welcomed and participants readily engaged with the research. One example is that I never really understood the significance or cause of multiple leadership changes at Rumbalara. There was very little impact of these changes on my research. Each time there was a leadership change, the research team met with the new Chief Executive Officer, confirmed support for the partnership and continued with the research. To ensure quality of the process of data collection and analysis in Shepparton, reviewing the findings with the nominated Associate Investigator was essential. This provided an additional layer of analysis to confirm reliability of the methodology and accuracy of the findings. In comparison, I did not have a similar person to bounce the research off in Southern Adelaide but as a member of the community, I had much greater insight into the way that policy had been implemented in my own backyard.

8.5.3 Analysis

Analysing the policy documents and the case study results was an intentionally messy process. I found myself wresting with the documents, searching for Indigenous rights and angry when Indigenous rights were undermined or ignored in policy. I tried to build a coding framework for analysis that could neatly represent what I found in a structured way. As I realised rights are recognised across a spectrum and that the policy documents did not neatly fall into a particular category recognising rights, I had to broaden my thinking to incorporate the spectrum. Similarly, when I analysed the case study findings, I started with a coding framework for the Shepparton results but the contrast with Southern Adelaide results meant that an alternative framework was used. While there was an overlap of some key themes, revisions to analysis meant that once again, a structured coding framework where results could fit neatly into a predetermined structure was insufficient and could not reflect the ways that policy had been implemented in the case studies. While the initial coding frameworks were a guide for analysis, I had to weave concepts together by spreading quotes out across the floor and grouping key themes together.

This meant that I could not just sit at a desk and categorise findings. I had to sit in the mess of the research in order to make sense of the way that policy had been implemented. It is messy because of different expressions of power, problem representation, and unmet expectations for self-determination and the recognition of Indigenous rights. When participants were frustrated or hurt by the process of policy implementation, the emotion infuses the data, making it richer and more complex. As I read through participants quotes, I could hear their voices in my head and the slow collating of key themes was another mindful process. Therefore, a two-dimensional coding framework would not accurately represent either the process or outcome of data analysis. The description provided in the methodology chapter and detailed here in my reflection, gives a more accurate representation of how I analysed policy and case study results in a more dynamic way.

8.5.4 Writing

This more agile method of research also influenced my writing. I began the discussion chapter thinking I could just write up the answers to the research questions. This would have been a mistake. If I had limited the discussion to linear thinking I could have easily missed the significance of discussing sovereignty and self-determination. Therefore, with every draft of the discussion I pulled apart my plans and reread through participants quotes. This deconstruction or unravelling of my writing, helped me to stay connected to the heart of the research which is the never ceasing commitment to Indigenous rights and social determinants of Indigenous health, even in the face of generations of discrimination, marginalisation and dispossession. With every draft of the discussion Chapter, the metaphor of the “Bandaid for a bullet wound” emerged as the most important message from the thesis. I learned that policy that covers up the causes of inequity, cannot heal long term wounds. If I had stuck to just writing an answer to the research questions, I would not have done the research questions justice. The research questions allowed me to explore the importance of Indigenous rights, social determinants of Indigenous health and self-determination in a way that I could not have predicted, as long as I approached them drawing on the principles of research at the interface of knowledge.

8.6 “Honour what is shared”

Hart (2010) prioritised actions to “honour what is shared” as part of embedding Indigenous knowledge in research. In the Chapter 3 I outlined that I would honour what was shared through the analysis of research findings, workshops with research participant and the dissemination of results. These were important activities as an outward recognition of what was shared but at the same time, I internally processed the detail of what was shared and had to honour the voices of the research participants. As with my unravelling and weaving regarding time, the research process, analysis and writing, I had to resist compartmentalising what was shared into manageable pieces, and challenge myself to connect with the pain and frustration of policy implementation. When it was hard, I instinctively retreated away from the emotion but both my peer mentor and supervisors insisted that I engage with the most difficult part of this research in order to fully understand the challenge of policy implementation and to give voice to Indigenous knowledge and experiences. Then when participants shared their hope, even when they themselves felt constrained by implementing policy in the mainstream, I too remembered my hope for equity and justice. This hope is what drove me to do this research in the first place. I reflected on a conversation I had with my peer mentor when we hoped our children could grow up in an environment where there was no gap in life expectancy between them. I hold on to this hope even though I also understand the challenges of implementing policy in Australian society.

I commissioned an Aboriginal artist, Micky Barlow, in Southern Adelaide to create an artwork that depicts the transformational unlearning and reflection within this research. We sat together and talked through the research, and the challenges of decolonising methodology. We discussed the importance of unravelling and weaving for research at the interface of knowledge. The artwork shown in Figure 17, depicts both case studies and the large tree on the river symbolises me. The placement of the tree downstream respects the generations of knowledge that has come before me, but also that there is more learning still to come. The painting includes people gathered together, weaving, animals, homes, schools, hospitals and health clinics positioned along the paths which also symbolise my journey through the case studies. This artwork is a special memento from my research and with permission from the artist, can be shared with others through the dissemination of research findings.

Figure 17: PhD Painting by Micky Barlow, June 2020 (used with permission, photo by Emma George)

The artist encouraged me to attend a weaving workshop and in June 2020 I learned how to weave. As I sat with other women, I shared the story of my learning and unlearning and reflected on the significance of unravelling before I could weave in new knowledge. As I completed my thesis, I continued to weave to relax and embrace creativity, shown in Figure 18. My weaving has become a wall hanging and I have woven in some seeds to represent the way that when we scatter ideas in research, some of them will germinate and some will not. I will leave the edge of this piece unwoven so that I can add to it at any time but also to remind me that decolonisation is an active an ongoing process.

Figure 18: Weaving (Photos by Emma George)

8.7 Final reflection

As I consider all that I have learned through my PhD, I must continue to reflect on my role as a non-Indigenous researcher. I commit to seeking partnerships with Aboriginal and Torres Strait Islander colleagues so that Indigenous knowledge is valued and privileged. My world view has shifted during the four years of this PhD and I cannot ignore racism, or the undermining of Indigenous rights. Once something invisible becomes visible, it cannot be unseen. Armed with new knowledge on policy, rights, social determinants of Indigenous health and self-determination, I must channel my hope into research that addresses the deep wounds that have caused inequity in Australia. If it is true that to be an occupational therapist is to be an activist, then this research has prepared me well to advocate for better policy and implementation.

APPENDICES

Appendix A: Social determinants of Indigenous Health and Indigenous Rights in Policy: A scoping review and analysis of problem representation

iipj.org

The International Indigenous Policy Journal

Volume 10 | Issue 2 Article 4

April 2019

Social Determinants of Indigenous Health and Indigenous Rights in Policy: A Scoping Review and Analysis of Problem Representation

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Recommended Citation

George, E. , Mackean, T. , Baum, F. , Fisher, M. (2019). Social Determinants of Indigenous Health and Indigenous Rights in Policy: A Scoping Review and Analysis of Problem Representation. *The International Indigenous Policy Journal*, 10(2) .
DOI: 10.18584/iipj.2019.10.2.4

Social Determinants of Indigenous Health and Indigenous Rights in Policy: A Scoping Review and Analysis of Problem Representation

Abstract
Despite evidence showing the importance of social determinants of Indigenous health and Indigenous rights for health and equity, they are not always recognised within policy. This scoping review identified research on public policy and Indigenous health through a systematic search. Key themes identified included the impact of ongoing colonisation; the central role of government in realising rights; and the difficulties associated with the provision of mainstream services for Indigenous Peoples, including tokenism towards Indigenous issues and the legacy of past policies of assimilation. Our approach to problem representation was guided by Bacchi (2009). Findings from the review show social determinants of Indigenous health and Indigenous rights may be acknowledged in policy rhetoric, but they are not always a priority for action within policy implementation.

Keywords
social determinants of Indigenous health, rights, self-determination, problem representation

Acknowledgments
This work was supported by the NHMRC Centre of Research Excellence on the Social Determinants of Health Equity: policy research on the social determinants of health equity (APP1078046). The authors acknowledge the contribution of peer reviewers and thank them for their feedback and recommendations, which enhanced the quality of the article.

Disclaimer
The authors of this article acknowledge that we live and work on the traditional lands of the Kaurna people of the Adelaide plains.

Social Determinants of Indigenous Health and Indigenous Rights in Policy: A Scoping Review and Analysis of Problem Representation

According to the Commission on the Social Determinants of Health (2008), the social determinants of health are the conditions in which people are born, grow, live, work, and age. Inequalities in health are caused by the unfair distribution of power, income, goods, and services, and consequences are evident in limited access to health care, education, work, leisure, and healthy communities. In addition, there is growing recognition of the social determinants of Indigenous health, which recognise the adverse health impacts of issues such as racism, and the health benefits of strong cultural identity, connection to country, sovereignty, and Indigenous knowledges (Anderson, Baum, & Bentley, 2007; Carson, Dunbar, Chenhall, & Bailie, 2007). These perspectives reflect an Australian Aboriginal and Torres Strait Islander definition of health, which is:

> Not just [about] the physical well-being of an individual but refers to the social, emotional, and cultural well-being of the whole community, in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their community. (National Aboriginal Community Controlled Health Organisation, 2006, Aboriginal Health section, para. 1)

Similarly, Durie (1985) described a Maori definition of health founded upon spiritual, psychic, and family dimensions, rather than just a physical biomedical approach to health. He emphasised the importance of cultural factors that affect the health of communities as a whole. In addition, Canadian research on health as defined by First Nations people showed that health transcends an individual perspective to include family, community, and the environment (Levesque & Li, 2014; Levesque, Li, & Bohemier, 2013).

Research has shown there are significant deficits in conceptualisation and implementation of social determinants of health in policy. Carter, Hooker, and Davey (2009) analysed the way that social determinants were acknowledged, audited, recommended, or linked with aims in cancer policy. In their view, where social determinants were acknowledged, the naming of social determinants appeared to be ritualistic, "an incantation to be said before the policy or plan got on with the real business of reducing risk" (p. 1451). They explained that inclusion of social determinants in a policy's aims did not necessarily lead to recommendations for action. Another study by Phillips et al. (2016) explored social determinants in Australian child and youth health policies. They found that all of the policies analysed acknowledged social determinants to some extent; however, the strategies proposed to address these issues were few and limited in scope. They concluded that the broader determinants of health are either considered outside the scope of the health sector, or not a priority. A third study by Fisher, Baum, MacDougall, Newman, and McDermott (2016) found that, although social determinants were generally acknowledged in Australian health policy documents, "policies generally did not recognise broader policy settings affecting the overall distribution of socioeconomic resources as determinants of health inequities" (p. 553). In addition, key determinants of Indigenous health such as racism, cultural identify, or strong community governance structures were very rarely identified in policies (Carson et al., 2007). The lack of social determinants in policy is prevalent across colonised countries and Indigenous Peoples globally have experienced health inequity and lower life expectancy than non-Indigenous people. Policy research can advance understanding of more effective ways to address social determinants of health and promote the fair distribution of health in society (Baum & Friel, 2014). However, research has shown that the implementation of policy does not always result in effective action on health inequities affecting Indigenous Peoples (Comino, Knight, & Webster, 2012; Dwyer, Kelly, Willis, & Mackean, 2011; Osborne, Baum, & Brown, 2013; Ziersch, Gallaher, Baum, & Bentley, 2011). This may be in part because policy implementation fails to support self-determination (Tynan, 2013) and does not attend to social determinants of Indigenous health (Carson et al., 2007). In this article, we recognise similar experiences of discrimination and inequality across high-income colonised countries; therefore, we have focused our research on policy and social determinants of health in Australia, New Zealand, Canada, and the United States of America. Collectively, we acknowledge there are Indigenous Peoples within each nation with shared experiences of inequity but with diverse cultural identities.

The United Nations (2007) adopted the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) in 2007. This affirmed the dignity and rights of the world's Indigenous Peoples. The Declaration addressed both individual and collective rights including equality and freedom from discrimination, self-determination, and the maintenance and strengthening of Indigenous institutions (Healey, 2014). Self-determination is the right to freely determine political status and to pursue economic, social, and cultural development (Australian Human Rights Commission, n.d.). The Declaration has been described as important because it opposes discrimination and assimilation policies; however, Davis (2007) acknowledged it is a non-binding human rights instrument, and it was not initially endorsed by the Australian, New Zealand, Canadian, or American governments.

In order to understand what does and does not work to improve Indigenous health, we must examine the extent to which Indigenous knowledge, a vital component, is incorporated into action on social determinants of health. Durie (2005) described Indigenous knowledge as dynamic and based on collective and holistic principles, rather than individual or reductionist ones (Hart, 2010). Indigenous knowledge is shared and communicated orally and through culture. It is stored in "people's memories and activities and is expressed in stories, songs, folklore, proverbs, dances, myths, cultural values, beliefs, rituals, community laws, local language and taxonomy, agricultural practices, equipment, materials, plant species and animal breeds" (Grenier, 1998, p. 2). Sherwood (2010) and Hart (2010) both described Indigenous knowledge as relational and communally oriented, as well as founded on notions of respect, responsibility, and reciprocity. Hernandez (2012) explained that Indigenous knowledge is fundamentally different than Western scientific knowledge, and that research has most often taken power and legitimacy away from Indigenous knowledge. However, Indigenous knowledge is important in understanding social determinants of Indigenous health. It is necessary in promoting policy implementation and action aligned with broader definitions of health and well-being.

Focus of Literature Review

Bacchi (2009) proposed that policy analysis should explore the ways particular issues are conceived as "problems," how problems are represented in policy, and how we are governed by these problem representations. We began with a literature review to scope and analyse the literature that focuses on policy relevant to Indigenous people globally, the social determinants of health, and Indigenous rights. This review sought to answer the question: In what ways are social determinants of Indigenous health and Indigenous rights recognised in public policy? Then we drew on a Bacchian approach to analyse problem representation in order to identify the ways in which problems have been framed.

Methods

Search Strategy

A scoping review of the literature allows synthesis of research evidence to map existing literature, summarise knowledge gaps, and make recommendations for future research (Peters et al., 2015). Our search strategy was designed to identify literature addressing themes of Indigenous rights and social determinants of Indigenous health in policy relevant to the last decade. The authors' knowledge and experience with Australian policy informed the search; however, we sought literature from comparable colonised countries: New Zealand, Canada, and the United States. We recognise that Indigenous Peoples in these countries are subject to health inequities similar to those affecting Aboriginal and Torres Strait Islander people in Australia (Jackson Pulver et al., 2010). Therefore, the search strategy was not limited to literature only in the Australian context. In collaboration with a university librarian, subject categories and key search terms (shown in Table 1) were identified and the search was initially run through these databases: Medline, Scopus, Informit, ProQuest, and Australian Policy Online. Sources that were not in English were excluded.

Table 1. Literature Search Categories and Terms

Categories	Search Terms
Health	health* OR wellbeing OR "well-being"
Policy	policy OR policies OR "self determin*" OR decoloni* OR colonis* OR coloniz* OR assimilat* OR power* OR empower*
Social Determinants of Health	social* OR socio* OR determinant* OR marginali* OR poverty OR welfare OR cultur* OR acculturat* OR psychosocial* OR family* OR families OR medicali* OR urbani* OR network* OR support OR literate OR literacy OR education* OR employment OR unemploy*
Indigenous	Indigenous OR Indigeneit* OR Aborigin* OR "Torres Strait*" OR "First Nation*" OR "First People*" OR Maori OR "American Indian*" OR Inuit* OR Métis

Alerts were created through the databases to identify any new records as they were published. Additional searches were run through the Closing the Gap Clearinghouse website and Australian Indigenous Health*Info*Net to identify Australian records that may have been missed by the larger databases. In order to search for further literature related to New Zealand, Canada, and the United States, we included a targeted search within two relevant international peer-reviewed journals. The peer review of this article led to suggestions for additional sources, which were included in the results. Records were excluded if they focused on program evaluation and outcomes rather than on policy, or if the literature focused on recommendations for policy in the future, rather than research on current policy. This narrowed the results to focus on policy and implementation rather than service evaluation. Grey literature from a variety of sources was included to add critical commentary and insight on policy implementation. All records were imported into NVivo11 qualitative analysis software and coded using thematic analysis. The process and results of the search strategy are shown in Figure 1.

Thematic Analysis

An initial thematic analysis of the literature was done using NVivo software. A coding framework was developed that allowed for flexibility and development of additional codes to capture new concepts as they emerged. Themes that were specifically sought from the literature included social determinants of Indigenous health, Indigenous rights, and self-determination. Other themes on colonisation, the role of government, and the provision of mainstream services emerged from the data. In addition, records were cross-examined to explore themes that were missing or clustered in only certain types of literature (e.g., peer-reviewed literature, government and non-government reports, policy audits, commentaries, etc.). The analysis enabled identification of gaps in the literature.

We then used Bacchi's "What's the Problem Represented to be" approach to critically analyse results from the thematic analysis and to identify the ways in which problems have been framed (Bacchi, 2009). Problem representation can be explicit or implicit, and it can be underpinned by assumptions that lead some things being problematized and others not. Therefore, analysis was both an inductive data driven approach to identify themes that emerged from the literature, and deductive where preconceived themes were sought from the literature as recommended by multiple authors (Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005; Saks & Allsop, 2007). Bacchi's (2009) approach allowed us to explore the following questions:

- How are Indigenous Peoples, health, and rights represented as policy problems?
- How have such problem representations come about?
- What are the effects produced by such problem representation in limiting policy goals and strategies, or silencing other alternatives?

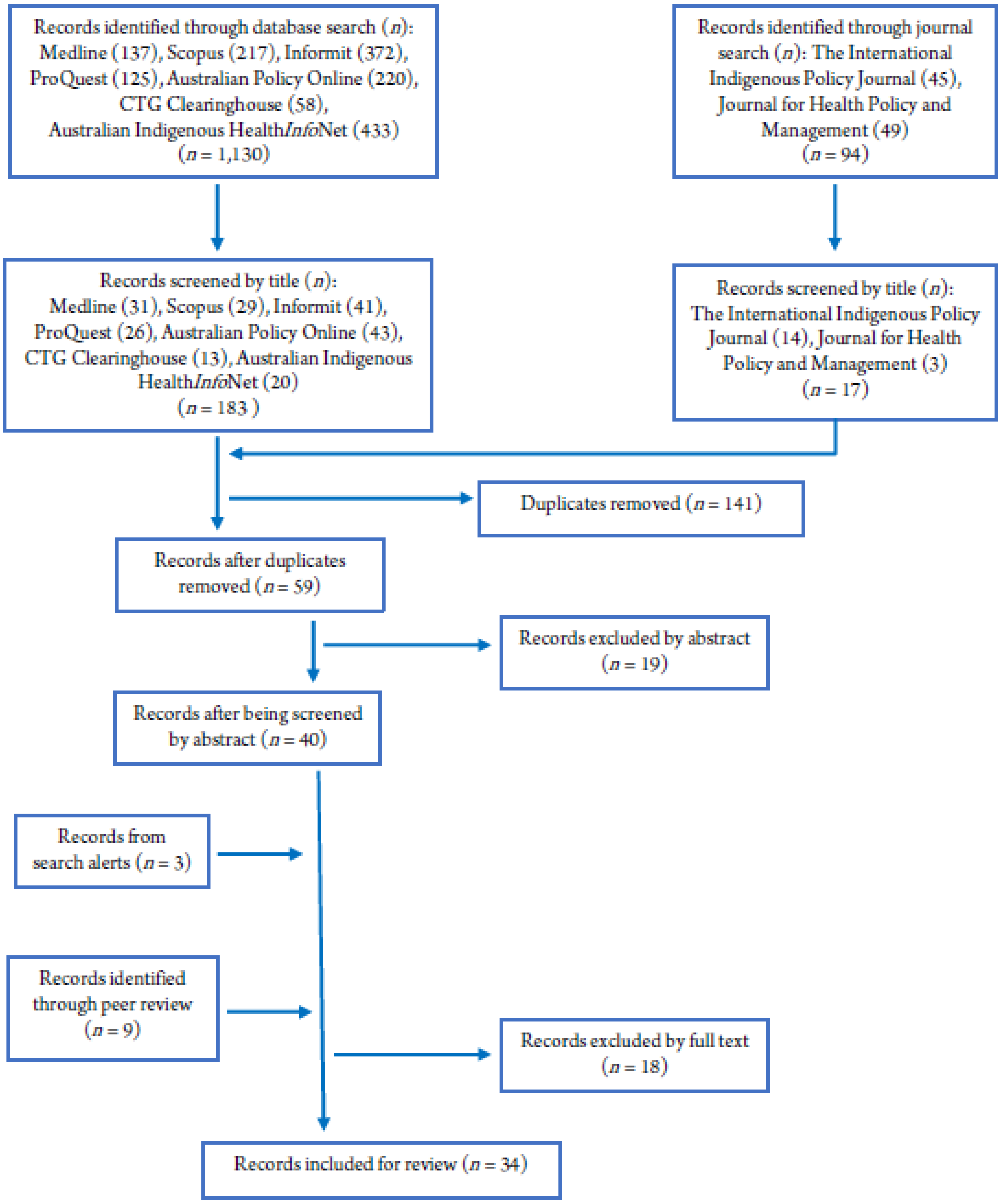

Figure 1. Scoping review search strategy and results.

Results

A total of 34 records were included in this scoping review (Figure 1). Records included an edited book chapter, peer-reviewed journal articles, government and non-government reports, commentaries, conference papers, and a public lecture. The diverse genres provide alternate perspectives on policy and implementation with regard to social determinants and Indigenous populations. Among the records, 19 were primarily focused on an Australian context, 10 Canadian (one of these included a comparison with Norway, and two others compared the Canadian context with other colonised countries), three from New Zealand (one of these included a comparison to social policy in Fiji), and two from the United States. The included sources are provided in Table 2.

Overview

As expected, themes of social determinants of health, Indigenous rights, and self-determination were discussed throughout the literature. Our results showed that the ways that social determinants of Indigenous health and Indigenous rights are recognised in policy are contested. Much of the literature recognised social determinants of Indigenous health, especially the importance of culture. However, even when social determinants and rights are written into policy, this does not always result in action in these areas (Australian Institute of Health and Welfare, 2016; Cooper, 2011; Klein, 2015; Robertson, Conigrave, Ivers, Usher, & Clough, 2012; D. Smith, 2007).

In addition, the ongoing impact of colonisation emerged as a central theme. The literature highlighted a contrast between a colonising deficit-based approach to policy and one that stresses the value and strength of Indigenous cultures and individual or community capabilities (Carter et al., 2009; Klein, 2015; Sullivan, 2011). Even though cultural inheritance and maintenance may be acknowledged in policy as important for individuals (Australian Institute of Health and Welfare, 2016), Cooper (2011) argued that Indigenous expression of culture through language and use of traditional lands "are not generally considered indicators of 'progress' by governments" (p. 14). He went on to suggest that culture in this sense has been seen as a problem, rather than part of the solution, and therefore has been excluded from policy.

Other themes that emerged from the data analysis focused on the role of the government and on the provision of mainstream services for Indigenous Peoples. Within both themes, the literature reviewed emphasised a need for commitment across governments and communities to working together (Bishop, Vicary, Browne, & Guard, 2009; Cooper, 2011; Kelaher et al., 2015; Meo-Sewabu & Walsh-Tapiata, 2012; Victorian Council of Social Service, 2016). However, there was also a consistent view that the depth or quality of collaboration, consultation, engagement, involvement, partnership, or participation reported was variable. Browne et al. (2017) highlighted that policy actors in their study advocated for "genuine" or "meaningful" partnerships, suggesting that previous partnerships had not reflected these characteristics.

Table 2. Summary of Sources Included in the Analysis

Author	Date	Country	Source Type	Themes Identified
1. Anderson	2007	Australia	Commentary	• Colonisation • Indigenous Rights and Self-Determination
2. Australian Institute of Health and Welfare	2016	Australia	Government Report	• Role of Government • Social Determinants of Indigenous Health • Indigenous Rights and Self-Determination
3. Bishop, Vicary, Browne, & Guard	2009	Australia	Peer-Reviewed Case Study	• Colonisation • Indigenous Rights and Self-Determination
4. Black & McBean	2016	Canada	Peer-Reviewed Policy Analysis	• Colonisation • Social Determinants of Indigenous Health • Indigenous Rights and Self-Determination
5. Brown	2009	Australia	Peer-Reviewed Policy Literature Review	• Colonisation • Mainstream Services • Indigenous Rights and Self-Determination
6. Browne, de Leeuw, Gleeson, Adams, Atkinson, & Hayes	2017	Australia	Peer-Reviewed Policy Analysis	• Colonisation • Mainstream Services • Social Determinants of Indigenous Health
7. Cooke & McWhirter	2011	Canada	Peer-Reviewed Policy Analysis	• Colonisation • Mainstream Services
8. Cooper	2011	Australia	Non-Government Report	• Colonisation • Role of Government • Mainstream Services • Social Determinants of Indigenous Health • Indigenous Rights and Self-Determination

Table 2. Summary of Sources Included in the Analysis (continued)

Author	Date	Country	Source Type	Themes Identified
9. Cox	2011	Australia	Commentary	• Colonisation • Role of Government
10. Dwyer, Boulton, Lavoie, Tenbensel, & Cumming	2014	Canada, New Zealand, and Australia	Peer-Reviewed Policy Analysis	• Colonisation • Role of Government • Mainstream Services
11. Fisher, Battams, McDermott, Baum, & MacDougall	2018	Australia	Peer-Reviewed Policy Analysis	• Role of Government • Social Determinants of Health • Indigenous Rights and Self-Determination
12. Hill	2008	United States	Peer-Reviewed Policy Literature Review	• Colonisation
13. Hudson	2009	Australia	Non-Government Report	• Role of Government
14. Kelaher, Sabanovic, La Brooy, Lock, Uddin, & Brown	2015	Australia	Non-Government Report	• Role of Government • Indigenous Rights and Self-Determination
15. Kelly	2011	Canada	Peer-Reviewed Policy Analysis	• Colonisation • Role of Government • Indigenous Rights and Self-Determination
16. Klein	2015	Australia	Non-Government Report	• Colonisation • Mainstream Services • Social Determinants of Indigenous Health • Indigenous Rights and Self-Determination

Table 2. Summary of Sources Included in the Analysis (continued)

Author	Date	Country	Source Type	Themes Identified
17. Lavoie, Boulton, & Gervais	2012	Canada & New Zealand	Peer-Reviewed Policy Analysis	• Colonisation • Indigenous Rights and Self-Determination
18. Lavoie	2014	Canada and Norway	Peer-Reviewed Policy Analysis	• Colonisation • Mainstream Services • Indigenous Rights and Self-Determination
19. Lavoie & Dwyer	2016	Canada and Australia	Peer-Reviewed Policy Analysis	• Colonisation • Role of Government • Indigenous Rights and Self-Determination
20. Lawrence	2013	Australia	Commentary	• Colonisation
21. Lindstedt, Moeller-Saxone, Black, Herrman, & Szwarc	2017	Australia	Peer-Reviewed Policy Analysis	• Colonisation • Social Determinants of Indigenous Health
22. Meo-Sewabu & Walsh-Tapiata	2012	New Zealand & Fiji	Peer-Reviewed Policy Analysis	• Colonisation • Indigenous Rights and Self-Determination
23. Mitchell & Macleod	2014	Canada	Peer-Reviewed Policy Analysis	• Colonisation • Indigenous Rights and Self-Determination
24. Munshi, Kurian, Morrison, & Morrison	2016	New Zealand	Peer-Reviewed Policy Analysis	• Colonisation
25. Robertson, Conigrave, Ivers, Usher, & Clough	2012	Australia	Peer-Reviewed Qualitative Research	• Colonisation • Social Determinants of Indigenous Health • Indigenous Rights and Self-Determination

Table 2. Summary of Sources Included in the Analysis (continued)

Author	Date	Country	Source Type	Themes Identified
26. Ronald & Koea	2013	New Zealand	Edited Book Chapter	• Colonisation • Mainstream Services • Social Determinants of Indigenous Health • Indigenous Rights and Self-Determination
27. Russell	2010	Australia	Commentary	• Colonisation
28. Shewell	2016	Canada	Peer-Reviewed Policy Analysis	• Colonisation • Indigenous Rights and Self-Determination
29. Smith	2007	Australia	Conference Paper	• Colonisation • Role of Government • Mainstream Services • Social Determinants of Indigenous Health • Indigenous Rights and Self-Determination
30. Stanley	2011	Australia	Public Lecture	• Colonisation • Indigenous Rights and Self-Determination
31. Sullivan	2011	Australia	Non-Government Report	• Role of Government • Mainstream Services • Indigenous Rights and Self-Determination
32. Unal	2018	United States	Peer-Reviewed Policy Analysis	• Colonisation • Role of Government • Mainstream Services • Social Determinants of Indigenous Health • Indigenous Rights and Self-Determination

Table 2. Summary of Sources Included in the Analysis (continued)

Author	Date	Country	Source Type	Themes Identified
33. Victorian Council of Social Service (VCOSS)	2016	Australia	Non-Government Report	• Role of Government • Mainstream Services • Social Determinants of Indigenous Health • Indigenous Rights and Self-Determination
34. Wilmot	2018	Canada	Peer-Reviewed Policy Analysis	• Colonisation • Role of Government • Mainstream Services • Social Determinants of Indigenous Health • Indigenous Rights and Self-Determination

Theme 1: Colonisation Past and Present

Multiple authors viewed colonisation as a determinant of the health of Indigenous Peoples with multiple adverse impacts (Brown, 2009; Klein, 2015; Lavoie, 2014; Lavoie & Dwyer, 2016; Munshi, Kurian, Morrison, & Morrison, 2016; Wilmot, 2018). Unal (2018) explained that colonisers to the United States of America drew on doctrines of discovery and conquest to dispossess Indigenous Peoples from land and to challenge sovereign rights. Cooper (2011) argued that colonial policies that dislocate Indigenous Peoples from their homelands, prevent Indigenous self-determination, undermine economic and social development, and fragment families are directly linked to the poor health of Indigenous children globally. Following from this, he surmised that Australian policies have assumed control of the lives of Aboriginal people, resulting in "increased feelings of frustration, disempowerment, stress and anxiety and the associated incidence of chronic illness" (p. 11).

In addition, Black and McBean (2016) described colonisation as destructive, with far reaching consequences for Aboriginal Peoples in Canada. Peer-reviewed literature from both Australia (Bishop et al., 2009; Brown, 2009; Browne et al., 2017; Lindstedt, Moeller-Saxone, Black, Herrman, & Szwarc, 2017; Robertson et al., 2012; Stanley, 2008) and Canada (Cooke & McWhirter, 2011; Mitchell & Macleod, 2014; Shewell, 2016) described the damage caused by past policies of segregation, marginalisation, and assimilation. One particularly damaging characteristic of colonisation described was the forced removal of Indigenous children from families in Australia, the United States, and Canada (Black & McBean, 2016; Brown, 2009; Hill, 2008; Lavoie, 2014; Mitchell & Macleod, 2014; Shewell, 2016; Unal, 2018). Bishop et al. (2009) argued that Aboriginal children are still removed from families in Australia, but in a more sophisticated manner through the welfare system, noting that while current policies are written to focus on "child welfare" rather than forced removal, Aboriginal children are "still removed at a rate over six times more than non-Aboriginal children" (p. 113). Lindstedt et al. (2017) stated that in 2015 Aboriginal and Torres Strait Islander children were living in out of home care at a rate of 52.5 per 1000 children, compared to 8.1 per 1000 children for the total population, indicating the rate of removal was 9 times more likely for Indigenous children.

The grey literature from the non-government sector also recognised ongoing impacts of colonisation. Klein (2015) described Australian policies as paternalistic, directive, and deficit based. D. Smith (2007) argued coercion is a policy instrument to enable government control over Aboriginal people, and this has disempowered Indigenous Peoples since colonisation. She argued that "the history of Indigenous Affairs in Australia shows that coercion rarely leads to sustained positive outcomes. On the contrary, often it has led to unintended consequences that have exacerbated problems and created profound misery on the ground" (p. 7). An example of "failed policy" (Russell, 2010) attributed to ongoing colonisation was the Australian government's Northern Territory Emergency Response (Anderson, 2007; Cooper, 2011; Cox, 2011; Lawrence, 2013; D. Smith, 2007), about which Brown (2009) stated that "developments in the Northern Territory demonstrate that governments are still willing to exercise strict and punitive controls over Aboriginal individuals and communities" (p. 1563).

Black and McBean (2016) argued that decolonisation in policy would reflect a more holistic approach to addressing the health concerns of Indigenous communities. There were five sources that drew attention to decolonisation in policy through the Treaty of Waitangi in New Zealand; this included the three sources that focused on policy in New Zealand and two other comparative studies (Dwyer, Boulton, Lavoie, Tenbensel, & Cumming, 2014; Lavoie, Boulton, & Gervais, 2012; Meo-Sewabu & Walsh-Tapiata, 2012; Munshi et al., 2016; Ronald & Koea, 2013). Lavoie (2014) explained that New Zealand was the final British colony to be settled and this government was committed to avoiding the complex and violent experiences of other colonies, and Maori people were able to exert their sovereign rights (Ronald & Koea, 2013). As a result, integration was prioritised over marginalisation or containment, and this led to the Treaty of Waitangi. This treaty helps incorporate Maori values and ideology into social and health policies. The Maori concept of whanau ora (family health) has become a priority for health services promoting a focus on well-being more aligned with an Indigenous definition of health (Dwyer et al., 2014). The Treaty of Waitangi provides an example of policy that does not represent Indigenous Peoples as a policy problem. While the policy implications of the Treaty remain contested (Ronald & Koea, 2013), it has been shown to provide a framework for collaboration (Carter et al., 2009) because consultation with Maori on policy matters is required by law (Munshi et al., 2016). Ronald and Koea (2013) explained, "any discussion concerning the health of Maori in modern society must consider the historical, cultural and social context in which Maori have arrived in the 21st century" (p. 173). Maori people have fought for their right to self-determination since the Treaty was first signed in 1840. Meo-Sewabu and Walsh-Tapiata (2012) highlighted that there are lessons to be learned from Maori advocates who have "determinedly reclaimed and revitalised many aspects of their culture in order to preserve and transfer these to future generations" (p. 306). They argued that cultural preservation is essential, and policy must incorporate a commitment to human rights and an Indigenous concept of health and well-being. Unal (2018) described treaties with Indigenous people in the United States as a cornerstone of policy, but further explained that they have been limited in reach and time. These treaties do not carry the same weight as the New Zealand Treaty of Waitangi because implementation is discretionary and shaped by funding rather than community need.

The Canadian policy context is built upon treaty obligations; whereby the government has an obligation to assume responsibility for the health of First Nations people (Lavoie & Dwyer, 2016). In addition, Canadian constitutional recognition acknowledges the rights of First Nations, Inuit, and Métis to self-government. Wilmot (2018) explained that this provides a foundation for decolonisation with the potential to improve cultural sensitivity with the health care system and include more holistic and collective approaches to health and well-being. Kelly (2011), Lavoie and Dwyer (2016), and Wilmot (2018) all recognised that there has been a shift in Canadian policy from assimilation towards advocacy and self-governance, especially in the Province of British Columbia. However, Wilmot (2018) argued that the legacy of colonialism remains a barrier to implementing decolonising policy because First Nations people continue to be perceived as "inferior and exotic" and "health care for First Nations people has been seen as a separate, marginal matter" (p. 13).

Theme 2: Role of Government

In addition to criticism of colonial policies and their enduring effects, there was also criticism of contemporary policy implementation and the role of government, which added to our understanding of how problem representations have come about. Unal (2018) explained Indigenous health policy has a "long, complicated and often turbulent history ... resulting in complicated interactions between federal, state, tribal, and other programs with various funding sources and systems of governance" (p. 267). Kelly (2011) attributed jurisdictional gaps and longstanding debate between levels of government to the uncoordinated and fragmented health system. Cooper (2011) argued that policy created in "silos" leads to poorly coordinated objectives and outcomes across government departments. Cox (2011) suggested that Australian policies have been ineffective and not often evaluated. Kelaher et al. (2015) maintained that policy evaluations have concentrated on the achievement of defined outcomes at the expense of process. More specifically, Sullivan (2011) described national Australian policies such as the National Indigenous Reform Agreement as bound by "political shackles" (p. 19). He argued that the structure of these agreements, which tie federal and state governments to each other, has resulted in "solutions" that cannot respond to local problems. Fisher, Battams, McDermott, Baum, and MacDougall (2018) highlighted an exception to this in Australia in the National Aboriginal and Torres Strait Islander Health Plan. In this policy, community control and partnership between Indigenous leaders and the government was seen as a priority, which contrasted Indigenous leaders' assessment of past policy processes (including the National Indigenous Reform Agreement) in which attempts to form partnerships were inadequate. Fisher et al. (2018) argued that this leadership and advocacy was cruicial in the successul intergration of social determinants of Indigneous health into national health policy. D. Smith (2007) noted that government has a role in creating broader complex policy processes that are reflected in the unnecessary multiplication of programs and onerous funding processes. She argued that governments have not recognised the "extent to which government funding arrangements have exacerbated community and organisational dysfunction and poor governance" (p. 11). Hudson (2009) suggested that these funding complexities make accountability impossible and that "fewer than half of the Aboriginal health services file annual reports or complete their financial reporting requirements" (p. 1). In addition, accountability was described in the literature as primarily one-way where recipients of funding are accountable for the spending and outcomes. However, Dwyer et al. (2014) argued that tensions concerning accountability have deep roots in perspectives that problematize Indigenous Peoples. They advocated for an alternative understanding of accountability where identity is negotiated, and obligations and commitments are reciprocal. Wilmot (2018) agreed that reciprocal accountability would support collaboration and a transformation agenda away from colonising policy. Other literature highlighted a call for long-term funding (Anderson, 2007; Australian Institute of Health and Welfare, 2016; Cooper, 2011; Dwyer et al., 2014; Kelly, 2011; Lavoie & Dwyer, 2016) that would incorporate sustained and consistent effort across government (Victorian Council of Social Service, 2016) and reflect a stronger commitment to action on social determinants of health, which in turn would address issues of health inequity.

Theme 3: Mainstream Services

The literature described an expectation from the Australian, New Zealand, and Canadian governments that mainstream health services respond to the needs of Indigenous Peoples (Brown, 2009; Browne et al., 2017; Ronald & Koea, 2013; Victorian Council of Social Service, 2016) and the assumption that if this occurred Indigenous Peoples would then be more likely to use these services (Cooke & McWhirter, 2011; Cooper, 2011; Klein, 2015; Sullivan, 2011). Many discussions from "mainstream services" continue to contest both of these ideas and represent Indigenous people as a policy problem. Even when mainstream services adopt targeted strategies to meet needs of the Indigenous community, it can reflect a cheap, underfunded version of welfare that does not meet expectations of the community or the organisations (Lavoie, 2014). In an example from New Zealand, Maori people had concerns that mainstream services offered superficial appeasement, or at worst appropriation, of traditional customs, protocol, and culture (Ronald & Koea, 2013). Lavoie (2014) and Unal (2018) described mainstream services as a Western model of health care that excludes traditional health practices. Wilmot (2018) recognised the provision of services in Canada within a mainstream system as having the potential for greater Indigenous participation and closer coordination with community; however, the impact on health and well-being is difficult to quantify. The literature showed that, in the provision of mainstream services, the government decides what the most effective health care is without considering Indigenous knowledge, beliefs, traditions, or customs. This "undermines self-determination, self-government, and the sovereignty of [Indigenous] people" (Unal, 2018, p. 266). In addition, expectations that Indigenous health and well-being is best achieved by integrating people into mainstream services (Klein, 2015) is criticised by Sullivan (2011) as "normalisation." On one hand, normalisation can reflect a commitment to equality whereby all people have equal access to services. On the other hand, however, the process of normalisation undermines diversity and cultural practices and does not take account of how accessible services are to different groups. Sullivan (2011) and Lavoie (2014) both connected this process of normalisation to assimilation. Sullivan (2011) argued that current Australian policies reflect this type of normalisation. Cooper (2011) argued that requiring Aboriginal Peoples to access mainstream services subjects them "to increased levels of government control, surveillance and intervention in the name of addressing disadvantage and community dysfunction" (p. 19). In addition, Dwyer et al. (2014) explained that mainstream service providers are bound by complex funding and report requirements that are subject to increased monitoring by funding bodies. This is another example of how Indigenous Peoples are represented as a problem. D. Smith (2007) suggested that while people may have to access mainstream services, "Indigenous people will never leave their culture to one side; they will not be assimilated" (p. 12). Despite access to mainstream services, Indigenous health and disadvantage has shown little improvement in Australia. Cooper (2011) concluded that the model needs reassessment because there is a silence in policy about alternatives, such as community-controlled health services.

Theme 4: Social Determinants of Indigenous Health

Action on social determinants, including cultural determinants, were identified as essential components to improve health in this review (Australian Institute of Health and Welfare, 2016; Black & McBean, 2016; Cooper, 2011; Klein, 2015; Lindstedt et al., 2017; Robertson et al., 2012; D. Smith, 2007; Sullivan, 2011). Ronald and Koea (2013) described a Maori definition of health that is connected to relationships with one another, community, and the land, which, in their view, is consistent with global Indigenous orientation towards holistic views of health and well-being. Both the article by Browne et al. (2017) and the report by the Victorian Council of Social Service (2016) recognised a holistic view of health and the importance of the social determinants of Indigenous health. However, Browne et al. (2017) highlighted that even though an Aboriginal definition of health may be quoted in policy documents, it does not always lead to holistic approaches to health in policy implementation. Unal (2018) explained that United States federal government acts may have laid a foundation for wide-ranging community-based health approaches, including social determinants of Indigenous health and self-determination, but implementation is lacking, and there has been no assurance of action on social determinants of Indigenous health. A specific example of policy that has recognised social determinants of Indigenous health is the Australian National Aboriginal and Torres Strait Islander Health Plan. Fisher et al. (2018) described the way that policy actors responded to a window of opportunity to challenge conventional problem definitions and to place social determinants of Indigenous health at the centre of health policy for the first time. Their analysis showed that despite a commitment to partnership and collaboration, this policy was unclear in implementation and was not fully funded. These findings suggest that the representation of Indigenous Peoples as the policy problem overshadows evidence supporting action on social determinants of Indigenous health. When Indigenous knowledge and understanding of health are identified in policy but not acted on, the position of "other" is maintained as interesting but not worthy of action. Wilmot (2018) argued that the devaluing of Indigenous knowledge in the health care system has had a negative impact on health and well-being.

Theme 5: Indigenous Rights and Self-Determination

There was consensus in the reviewed documents that UNDRIP should call on governments to account for the support of Indigenous rights in policy and practice. Black and McBean (2016) argued that the recognition of Indigenous rights and commitment to self-determination are essential for the health of Aboriginal Peoples. However, existing policies on Indigenous rights appear to be at best incompatible with the Declaration and at worst a violation of rights (Australian Institute of Health and Welfare, 2016; Cooper, 2011; Klein, 2015; Meo-Sewabu & Walsh-Tapiata, 2012; Mitchell & Macleod, 2014; Shewell, 2016). Cooper (2011) argued that the Australian government's actions within current policy breech many articles of the Declaration, such as those that refer to control and "Indigenous rights to self-determination, participation in policy development and implementation, and the ability to practise and maintain their unique cultures" (p. 2). Shewell (2016) suggested the initial resistance by Australia, New Zealand, Canada, and the United States governments to adopt the Declaration reveals "an inherent, ideological aversion to collective rights" (p. 188). Brown (2009) described self-determination as implemented in Australia as a "failed experiment" (p. 1562). She argued in general terms, without referring to the content of specific policies, that the move to embrace self-determination in Australian policy was conceived without infrastructure or resources to ensure sustainability. As a result, policy makers have continued to view Aboriginal and Torres Strait Islander people from a deficit perspective and represent them as policy problems. The outcome of these processes is often policies that contain hollow promises of Indigenous equality and that lack Indigenous political representation. D. Smith (2007) argued that successive Australian governments have fundamentally failed to invest in Indigenous self-governance despite cases in which Indigenous communities successfully "establish[ed] good governance" and thereby "secur[ed] important social, cultural and economic outcomes" (p. 9) using a strengths-based approach. The limited implementation and lack of funding for the National Aboriginal and Torres Strait Islander Health Plan, which included culture at the centre of health policy, is further evidence of the lack of action on policy that promotes social determinants of Indigenous health (Fisher et al., 2018). Lavoie and Dwyer (2016) highlighted that, without a treaty with Indigenous Peoples in Australia, self-determination is not a priority for the Australian government and constitutional reform may be required to fully address issues of governance and health equity.

On balance, the literature suggested that self-determination was lacking in policy. However, there were many examples of policy discussed in the literature that involved forms of engagement between policy makers and Indigenous Peoples. These were described in terms of consultation, collaboration, community engagement, partnership, or participation (Australian Institute of Health and Welfare, 2016; Bishop et al., 2009; Kelaher et al., 2015; Kelly, 2011; Meo-Sewabu & Walsh-Tapiata, 2012; Robertson et al., 2012; Ronald & Koea, 2013; Sullivan, 2011; Victorian Council of Social Service, 2016). Some considered Indigenous "voice" in policy as essential for improving health equity, especially given the history of marginalisation (Kelaher et al., 2015; Victorian Council of Social Service, 2016). However, we found in this review that the depth, quality, and purpose of Indigenous engagement in policy are contested and not the same as a commitment to self-determination. Black and McBean (2016) described consultation as a primarily "Western approach to Indigenous involvement" (p. 14) that actually disempowers Aboriginal people, resulting in negative outcomes for health and the environment. For example, Anderson (2007) described past Australian policy as "paternalistic," and it did not demonstrate a true commitment to working collaboratively. Similarly, Lavoie (2014) argued that few health services in Canada include Aboriginal input in decision making, service planning, or design. Strategies described in the literature used to engage with Indigenous Peoples and communities are varied and can be tokenistic (Kelaher et al., 2015). Consultation is a concept that appears to be understood differently by different parties (Australian Institute of Health and Welfare, 2016). Mitchell and Macleod (2014) argued that there is a rhetoric of consultation but a lack of subsequent action. An example from Klein (2015) suggested that consultation has been "more to convince local people of the merit of preconceived policies and principles than to inform the policies themselves, and allow deliberation and community participation" (p. 7). Fisher et al. (2018) also found that, even when policy is driven by consultation and a strength-based approach, action on social determinants of Indigenous health is often left unimplemented or unfunded.

Another approach to policy described in the literature, which would alter the representation of Indigenous Peoples and cultures to a strengths-based view, is the embedding of Indigenous knowledge into policy and action. This is described by Black and McBean (2016) as an important foundation for decolonisation and improving health. They proposed that the inclusion of Indigenous knowledge in policy ensures "the recognition of inherent rights, the ability of Indigenous communities to participate fully and meaningfully in decisions that affect their people, and the transition to self-determination" (p. 7). They advocated for a bottom-up approach to policy; whereby, Indigenous knowledge is respected and sought out by policy makers, which would shift the problem representation away from Indigenous

Peoples. Wilmot (2018) described the integration of knowledges as an overlapping of boundaries where two cultural worlds interface, are mutually identifiable and reinforced, but also interact. Respecting Indigenous knowledge in this way supports local Indigenous participation in policy making, and implementation can move beyond tokenistic consultation (Kelaher et al., 2015; Klein, 2015; Mitchell & Macleod, 2014) and paternalistic approaches to policy design and action (Anderson et al., 2007).

Discussion

The literature in this review showed barriers and limitations to recognising social determinants of Indigenous health and Indigenous rights in policy. The Treaty of Waitangi in New Zealand provided evidence of the way that Maori people have withstood the forces of colonisation and had this recognised in policy. The National Aboriginal and Torres Strait Islander Health Plan in Australia reframed policy problems and deficits and positioned culture at the centre of the policy. However, policy implementation has been inconsistent or tokenistic. The failure of policy action on social determinants of Indigenous health is not a result of a lack of advocacy and resistance to colonisation; rather, it highlights the lack of Indigenous rights and sovereignty in policy, which would support social determinants of Indigenous health. The themes identified in the results of this review all contribute to answering the following questions:

- How are Indigenous Peoples, health, and rights represented as policy problems?
- How have such problem representations come about?
- What are the effects produced by such problem representation in limiting policy goals and strategies, or silencing other alternatives?

The way that problems are framed and represented within policy determines the way that some problem solutions are actioned, and other possibilities are ignored or avoided (Bacchi, 2009). Policies that are paternalistic, directive, and deficit based (Klein, 2015) reflect a position of privilege and power held by policy makers or governments over their constituents. The policy focus on mainstream services for Indigenous people (Brown, 2009; Browne et al., 2017; Cooke & McWhirter, 2011; Cooper, 2011; Ronald & Koea, 2013; Unal, 2018) represents the problem as a failure of Indigenous Peoples to fit in with dominant, White social norms and institutions. With a solution that focuses on normalisation (Sullivan, 2011), Indigenous Peoples themselves are represented as the problem. For example, Pholi, Black, and Richards (2009) suggested that the Australian government's Closing the Gap strategy addressing health inequity reduces Aboriginal and Torres Strait Islander people to a set of indicators of deficits monitored by government-set targets where evidence may not be reliable or valid. They explained that the targets measure what is "wrong," what is "known," and how to "fix" Aboriginal and Torres Strait Islander people. This deficit discourse in policy was strongly criticised by Klein (2015) and Sullivan (2011) who explain that Indigenous Peoples and communities are represented as "other." This worldview that sees Indigenous Peoples and cultures as "other" is reflected in health care (Goodman et al., 2017) and in policy (Schofield & Gilroy, 2015). The exclusion of traditional healers from policy in the United States demonstrates the power of a Western worldview of health in positioning Indigenous knowledge outside of health. Unal (2018) explained that the lack of integration of traditional healers into health policy and service provision resulted in fear and distrust of government run services. The systemic racism leading to Indigenous Peoples being represented as "other" is also deeply engrained in society in colonial countries like Australia (Baum, 2015) and Canada (Elliott & De Leeuw, 2009).

From our Bacchian analysis, we conclude that both historical colonial policies and ongoing policy failings predominantly represent Indigenous Peoples as policy problems that require government intervention to solve. This deficit approach is likely to reduce effectiveness of policy because it silences potential policy actions focused on building resilience and strength within Indigenous cultures (Chandler & Lalonde, 1998; Victorian Health Promotion Foundation, 2011), which are essential social determinants of Indigenous health. When considering the history of colonisation and the impact on Indigenous Peoples, it becomes clear that this representation of Indigenous Peoples as the problem has been a dominant theme in past policies (Brown, 2009), along with the struggle for self-determination (Kelaher et al., 2015; Klein, 2015; Meo-Sewabu & Walsh-Tapiata, 2012; Mitchell & Macleod, 2014; Sullivan, 2011). Colonial policies of segregation, marginalisation, and assimilation have had lasting effects on Indigenous Peoples and the policy environment (Bishop et al., 2009; Brown, 2009; Browne et al., 2017; Cooke & McWhirter, 2011; Kelly, 2011; Mitchell & Macleod, 2014; Robertson et al., 2012; Shewell, 2016; Stanley, 2008; Unal, 2018; Wilmot, 2018). This colonial foundation supports the siloed structure of governments (Cooper, 2011; Sullivan, 2011) and ineffective policy (Cox, 2011). Historically, the dominance of a Western-centric approach has restricted sharing and influence of Indigenous knowledge outside of Indigenous communities, elevating colonial powers to a superior position (Goodman et al., 2017; Schofield & Gilroy, 2015; L. T. Smith, 2012; Wilmot, 2018). This power and ongoing nature of colonisation means the representation of Indigenous people as "other" or as a problem that needs to be fixed continues into current policy without consideration of the strength and importance of Indigenous knowledge. Sherwood (2010) argued that denying Indigenous knowledge further exacerbates the pain and injury caused by colonisation. Even though the literature revealed that collaboration and consultation with Indigenous Peoples is commonly mentioned in policy, the quality of this engagement is inconsistent and a does not constitute self-determination (Black & McBean, 2016; Klein, 2015; Lavoie, 2014). The process of participation in policy was described as primarily "Western" and as continuing to isolate or marginalise Indigenous Peoples. The examples of top-down policy, where governments hold power over Indigenous Peoples, can result in implementation that does not respond to the needs or strengths of Indigenous Peoples themselves. Government control over the lives of Indigenous Peoples (Cooper, 2011) and use of coercion as a policy instrument (D. Smith, 2007) have a negative impact on health and well-being.

On the question of alternative perspectives missing from policy and policy silences, the inconsistent value placed on an Indigenous view of health and the lack of self-determination suggests that Indigenous rights are missing from policy. Incorporation of rights would provide a normative basis for more effective policy approaches to address Indigenous health inequities within the countries covered by this review. The United Nations Declaration on the Rights of Indigenous Peoples (2007) could have been a catalyst for empowerment and recognition; however, Australia, New Zealand, Canada, and the United States all initially voted against it. Their opposition was in response to the term "self-determination" (Talbot & Verrinder, 2014), as well as resistance to the recognition of rights as part of current policy. The Australian Human Rights Commission (n.d.) stated that the loss of Indigenous rights is at the heart of Indigenous disadvantage and that "without self-determination it is not possible for Indigenous Australians to fully overcome the legacy of colonisation and dispossession" (Self Determination and Australia's First Peoples section, para. 5).

Mitchell and Macleod (2014) maintain that policies have often been developed and implemented in ways that are contradictory to the worldview of Aboriginal Peoples. In response to policies that are silent on Indigenous knowledge, Meo-Sewabu and Walsh-Tapiata (2012) in New Zealand called on Indigenous Peoples to look for solutions from "within" that reflect social determinants of Indigenous health. They advocated for policy with meanings, words, and ways of knowing that reflect Indigenous knowledge. In addition, Wilmot (2018) promoted policy at the boundaries of knowledge where different understandings of health can be used to reform health service delivery.

Inevitably, this review of the literature may not have captured all of the relevant literature. The additional sources included through targeted searches in international policy journals, together with sources suggested through peer review, support the comprehensive critique of the literature and problem representation in policy.

Conclusion

This scoping review of research literature, public policy, and Indigenous health has explored the ways that social determinants of Indigenous health and Indigenous rights are recognised and not recognised in policy. Our analysis showed that policies represent colonial approaches to power and that, while self-determination may be included in policy rhetoric, implementation of this principle is inconsistent or non-existent. The themes that emerged from the literature highlighted that colonisation in policy is ongoing. The structure of mainstream service provision in health and encouragement of Indigenous Peoples to use mainstream services was described as problematic for the health of Indigenous Peoples and restrictive of self-determination. The literature supported the important role of government in policy implementation but called for a stronger commitment to Indigenous rights. Collaboration across sectors was shown as an essential component in policy implementation; however, policy actors face challenges working together. The inclusion of social determinants of health in policy has been researched by Carter et al. (2009), Fisher et al. (2016), and Phillips et al. (2016), but a specific analysis on social determinants of Indigenous health would add depth to this field of policy analysis. In addition, research on the realisation of Indigenous of rights in policy implementation would explore the ways in which rights have been written into policy but action has been limited (Cooper, 2011; Shewell, 2016; D. Smith, 2007). The challenge remains for policy makers to support and encourage self-determination and decolonisation through recognition in policy, but also to ensure these commitments are translated into implementation.

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Appendix B: Interview guide

Introduction to the research:

Researcher: *This research is focused on the Closing the Gap (CTG) strategy on early childhood, and the way it has been implemented in Shepparton and Southern Adelaide. We are looking at health, education and other services in early childhood who implement CTG programs and help to meet CTG targets. We want to learn about how CTG is implemented and what influences implementation. We want to understanding the role of Indigenous rights, social determinants of Indigenous health, and self-determination in policy implementation. We are not evaluating the quality of services or efforts within programs. We acknowledge that services are committed to the important work that they do, often with limited resources. Therefore this research will focus on the way in which the CTG is implemented and how the implementation differs between contexts.*

Questions:

The work of the organisation:

- Can you tell me about the back ground of [*organisation name*]; how did it develop?
- Can you tell me about the aims and values of [*organisation name*]?
- Can you tell me about the current work of [*organisation name*]?

Supplementary questions:

- Have there been any particular challenges the organisation has had to face along the way?
- Can you tell me what aspects of your organisation you are particularly proud of?
- Are there any services or programs offered by other organisations for Aboriginal people within [*Shepparton/Southern Adelaide*] that you see as particularly valuable?

Supplementary questions:

- What about services or programs specifically for infants and children?

Partnerships

I'm interested to learn more about partnerships with other services or In your day to day operations, does your organisation interact with other services e.g. schools, health services? What does this involve?

- How would you assess the relationship between your organisation and these other organisations?
- In your dealings with other services have you encountered particular attitudes or assumptions from people that you thought were unfair, or just unhelpful?
- In your view, what could governments at Federal, State or Local level do to better support the work of your organisation?
- What's your relationship like with governments at Federal, State or Local level? Is it working for you? How does it impact or support your work?
- In CTG in early childhood, what does good leadership look like for you?

Closing the Gap

The Closing the Gap (CTG) strategy has clear targets to close the gap in life expectancy, child mortality, education, and employment. There have been two iterations of the strategy under the previous Rudd/Gillard government and the Abbott/Turnbull government. I am interested to learn more about your understanding of how CTG in relation to early childhood has been implemented and what influences policy implementation.

- Can you tell me about any programs you know of that have been implemented in this community under the CTG strategy?

  OR
- Can you tell me about any work that you or the organisation, have done specifically under the banner of 'CTG'?

  Probe:
    - Through CTG funding?
    - To achieve CTG targets?
    - Has this work been ongoing?
    - How has this work been successful?
    - What are the barriers to implementation?
    - What do you think influences the way that CTG is implemented?

- How do relationships with government enable CTG work to get done?
- From your perspective, have CTG programs changed over time?

  Probe:

    - How has CTG implementation changed under different governments? Better? Worse? Same?
- Who is responsible for leadership of implementing CTG and what influence do they have?

Social determinants of Indigenous health

I am interested to learn more about an Aboriginal definition of health and the social factors that have in impact on health and well-being of Aboriginal people.

- How would you define Aboriginal health?
- In what ways do you think the community adopt and Aboriginal view of health?
- What's your perspective on social factors that impact on Aboriginal people in this community? What does this mean for Aboriginal children? Is this different for non-Aboriginal people?
- In what ways do you think CTG includes a broad perspective of health?
- Do you think CTG policy reflects an Aboriginal definition of health?

  Probe:

    - In what way? Why/why not?
    - What do you see as the key issues for Aboriginal children in this region? Are there actions taking place within the community to address those issues?
- What opportunities do children have to express culture as an important part of their health?

Indigenous rights

I'm interested to learn your thoughts on Indigenous rights.

- How do you understand Indigenous rights? What does Indigenous rights mean to you? What do you think about the rights of Aboriginal children?
- How do you think Indigenous rights are valued or acted on in the community?
- How does the idea of Indigenous rights influence your work?
- How do you think Indigenous rights are valued or acted on at State or Federal government levels?
- How do you think Indigenous rights are recognised in the CTG strategy?
- Are there any ways in which Indigenous rights can be promoted in CTG?
- What are the barriers to promoting/recognising/upholding Indigenous rights?
- Who do you think is responsible for leadership in promoting Indigenous rights?
- What do you think about the statement "Aboriginal children have a rights to an Aboriginal childhood" and what do you think this means? What does this look like in Shepparton/Adelaide? OR Based on what you've described about Aboriginal health, and also Indigenous rights, what do you think about rights of Aboriginal children to childhood that reflects and Aboriginal definition of health?

Self-determination

- What does self-determination mean to you?
- What is the role of Aboriginal people in governance/decision making in your work? *Probe:*
    - What role do Aboriginal people have leadership at the community level? At the government level? And at the service/organisational level?
    - Do you think the roles of Aboriginal leaders and leadership is changing? What do you think influences leadership?
- What supports self-determination?
- What are the barriers to self-determination?
- In an ideal world, what would self-determination look like in your community, and Australia?

Probe:

  - What difference do you think self-determination would make for children in this community?
  - What difference do you think self-determination makes in policy implementation?

31. Who advocates for self-determination in this community?
32. What do you think drives leadership on self-determination?

Indigenous Knowledge

The last thing that I wanted to talk to you about is Indigenous knowledge. I'm interested in learning about how Indigenous knowledge is valued, respected and understood in a contemporary sense.

- From your perspective, to what extent do organisations/services in the community know, respect or embed Indigenous knowledge in their work?

  Probe:
  - Are there missed opportunities to include Indigenous knowledge??
  - How can organisations/services embed Indigenous knowledge in their work?
  - Is there anything documented in your strategic plan, mission, or vision statements about Indigenous knowledge?
  - What are the barriers to embedding Indigenous knowledge?
- To what extent do you think Indigenous knowledge is considered in the CTG strategy?

  Probe:
  - How could this have been better?
- If Indigenous knowledge was more widely respected and embedded across the community, what difference do you think this might make? What would the benefits be? How would this improve early childhood experiences?
- What other factors that we haven't talked about do you think would improve the early childhood experiences of Aboriginal children in your community?

Appendix C: Introductory Letter

Dear [*insert name*],

I am emailing/writing to [*delete one as required*] you to invite you to participate in a research project on ***Closing the Gap policy implementation and health equity***. The attached **Information Sheet** has more detail on the research. Our goal is to understand how Australian government policy actions to 'close the gap' do or do not work effectively to improve health and meet the needs and goals of Aboriginal and Torres Strait Islander peoples.

We are interested in the relationship between government policy actions and Aboriginal and/or Torres Strait Islander organisations and communities. We are interested in the role Aboriginal and/or Torres Strait Islander community-led organisations play in how policy is implemented.

The project is part of a NHMRC *Centre for Research Excellence* based at Flinders University and the ANU, doing policy research on the social determinants of health equity. This qualitative research project has two aims:

Aim 1: to examine how rights, self-determination and health equity can be advanced through community leadership, governance and organisations at a regional level, with effective support from government and public sector agencies. To achieve this aim we plan to a) conduct semi-structured interviews with Aboriginal leaders and/or representatives of Aboriginal community-led organisations in Southern Adelaide and Shepparton to gain their views on these issues; b) gather documentary material on the history of Aboriginal community organisations in Southern Adelaide and Shepparton.

Aim 2: to conduct a comparative case study on implementation of *Closing the Gap* policies, with a particular focus on policies on early childhood. The case study will involve two local-area qualitative studies working with members of Aboriginal and Torres Strait Islander organisations and communities in Southern Adelaide and in Shepparton, Victoria, who agree to participate in the research, using interviews, to gain their insights on policy implementation processes.

I would like to invite you to participate in a **research interview** to gather your views on these issues, especially in relation to Aim 2 above. The interview would be conducted by myself, at a time convenient to you. We hope to conduct interviews in person where possible, but can hold an interview by phone if needed. The interview would take around 60-90 minutes and be audio-recorded.

Information about themes to be covered and **confidentiality** are also in the **Information Sheet**. If you have any further questions, please contact me by email or on [*insert contact number*] during work hours.

You are free to make your own personal choice about whether or not to participate. Information about your decision, one way or the other, will remain confidential. All information provided in the interview would be treated in strict confidence, and every effort made to protect your anonymity throughout, including in research publications. (However, anonymity of participants cannot be wholly guaranteed, given that a participant might be identifiable by association with information presented in publications arising from the research.)

If you would be willing to participate, please indicate your consent either by **return email**, or by using the attached **Consent Form**. Form can be returned to emma.george@flinders.edu.au as a PDF, or sent by post to the address below.

Regards,

Emma George

B App Sc (OT), Mst Hlth & Int Dev, Mst Public Health
PhD Candidate
Southgate Institute for Health, Society and Equity | Flinders University
GPO Box 2100 Adelaide, SA 5001
Email: geor0187@flinders.edu.au OR emma.george@flinders.edu.au

This project has been approved by the Aboriginal Health Research Ethics Committee (a sub-committee of the Aboriginal Health Council of South Australia Inc: project number 04-16-697, AND by the Ethics Committee from Goulburn Valley Health: project number GV39/16, AND by the Flinders University Social and Behavioural Research Ethics Committee: project number 6786.

Appendix D: Information Sheet

INFORMATION SHEET

Closing the Gap policy implementation and health equity

This research project is located within the Centre of Research Excellence – Health Equity (CRE-HE). The aim of the CRE-HE is to research how Australian political and policy processes can work more effectively to address the social determinants of health, to improve health and reduce health inequities. A key focus of the CRE-HE is to understand how and why policy processes do or do not work effectively to improve health, wellbeing and equity for Aboriginal and Torres Strait Islander peoples. This qualitative research project has two aims:

Aim 1: to examine how rights, self-determination and health equity can be advanced through community leadership, governance and organisations at a regional level, with effective support from government and public sector agencies. To achieve this aim we plan to a) conduct semi-structured interviews with Aboriginal leaders and/or representatives of Aboriginal community-led organisations in Southern Adelaide and Shepparton to gain their views on these issues; b) gather documentary material on the history of Aboriginal community organisations in Southern Adelaide and Shepparton.

Aim 2: to conduct a comparative case study on implementation of *Closing the Gap* policies, with a particular focus on policies on early childhood. The case study will involve two local-area qualitative studies working with members of Aboriginal and Torres Strait Islander organisations and communities in Southern Adelaide and in Shepparton, Victoria, who agree to participate in the research, using interviews, to gain their insights on policy implementation processes.

Purpose of the study:

Health inequities arise from the interaction and distribution of social, cultural and economic resources known as the social determinants of health. Australian Federal, State and Territory health policies increasingly acknowledge the social determinants and include action in health and non-health policy domains. Despite this, the translation of this evidence into equity-focused multi-sectoral policy development and implementation has been slow. Furthermore, a 'drift' in policies' implementation strategies has been observed where the focus on structural change has shifted more to individual, biomedical or behaviour change approaches. This CRE-HE is significant because it will provide evidence on how political and policy processes could function more effectively to operationalise the social determinants to achieve better and more equitable health outcomes.

The purpose of the research under Aim 1 is to draw on the knowledge and experience of Aboriginal and Torres Strait Islanders community leaders and representatives of community-led organisations working at a local/regional level, to advance understanding of how relationships with governments and policy actions support or detract from community efforts to realise rights, achieve self-determination, and improve health and well-being.

The purpose of the comparative case study under Aim 2 is to examine the implementation of the *Closing the Gap* policies on early childhood at the local level during the period of 2013-2018. The case study will involve two local-area qualitative studies working with members of Aboriginal and Torres Strait Islander communities in Southern Adelaide and in Shepparton, Victoria. Other non-indigenous people who have played a significant role in implementation of *Closing the Gap* policies on early childhood within the two regions will also be invited to participate in the research.

What will I be asked to do?

We would like to invite you to participate in a face to face interview with a member of the research team to share your views in relation to Aim [*insert number*] or the research as described above.

The interview will take approximately 60-90 minutes, at a time and in a location that is convenient for you. The interview will be recorded using a digital voice recorder. Once recorded, the interview will be transcribed and stored as a computer file and destroyed once the results have been finalised.

Following the completion of interviews, you may be invited to attend workshops to discuss the themes and issues that arise from interview data. You will be asked to give consent to participate in the workshops and to treat group discussions as confidential.

What will I benefit from the being involved in the study?

The sharing of your experience will improve understanding of key factors within policy implementation processes affecting social determinants of Indigenous health, and the realisation of Aboriginal and Torres Strait Islander people's rights and self-determination in Australia. Your contribution to the research will enable improved understanding of the dynamics that support or impede health equity being a policy priority.

Will I be identifiable by being involved in this study?

All information provided would be treated in strict confidence, and every effort made to protect your anonymity throughout, including in research publications. However, anonymity of participants cannot be wholly guaranteed, given that a participant might be identifiable by association with information presented in publications arising from the research. You are free to make your own personal choice about whether or not to participate. Information about your decision, one way or the other, will remain confidential, and will not be provided by us to any other party within the department or elsewhere.

You will be provided with the transcript of your interview. You may identify any comments you want to remove, or to not be quoted directly. The audio recording and transcript of your interview will be stored electronically on a secure server for 5 years after the completion of the project, in accordance with Flinders University policy on research data storage. Only members of the research team will have access to this data.

Are there any risks or discomforts if I am involved?

Other people may be able to identify your contributions even though they will not be directly attributed to you. The investigators anticipate few risks from your involvement in this study. If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the researcher.

How do I agree to participate?

If, based on information provided, you would like to participate, you can indicate your consent by signing the consent form (to be returned by email as a PDF or by post); or by stating your willingness to participate in an email.

How will I receive feedback?

You will have the opportunity to review and amend a verbatim transcript of your interview either in electronic or hard copy, and prior to and use of the data in analysis or publication.

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This project has been approved by the Aboriginal Health Research Ethics Committee (a sub-committee of the Aboriginal Health Council of South Australia Inc: project number 04-16-697, AND by the Ethics Committee from Goulburn Valley Health: project number GV39/16, AND by the Flinders University Social and Behavioural Research Ethics Committee: project number 6786.

Appendix E: Consent Forms

Interview consent form: Shepparton case study

CONSENT FORM FOR PARTICIPATION IN RESEARCH (by interview)

I ………

am over the age of 18 years and hereby consent to participate in the research project **on Closing the Gap policy implementation and health equity,** which is being conducted under the *Centre for Research Excellence – Health Equity* (*CRE-Health Equity*) funded by the National Health and Medical Research Council.

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to audio recording of my information and participation.
4. I am aware that I should retain a copy of the information Sheet and Consent Form for Future reference.
5. I am aware that the recording and transcript will be stored electronically on a secure server for 5 years after the completion of the project.
6. I understand that:
    - I may not directly benefit from taking part in this research
    - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
    - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential. I understand however that anonymity cannot be wholly guaranteed and that I may be identifiable by association with information in publications arising from the research.
    - I may ask that the recording be stopped at any time, and that I may withdraw at any time from the interview without disadvantage.

Ethical approval for this research has been granted by the Human Research Ethics Committee, GV Health. If you have any concern and would like to discuss or make a complaint about the ethical conduct of this research please contact:

- A/Professor Vasudha Iyengar, Chairperson, HREC, GV Health on (03) 5832 2943 and Vasudha.Iyengar@gvhealth.org.au; or
- Dr Md Rafiqul Islam on (03) 5831 0035 and MdRafiqul.Islam@gvhealth.org.au

(A) Participant's signature……………………………………………………………………………………………Date……………………..

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name……..

Researcher's signature………………………………………………………………………………………………Date……………………..

7. I, the participant whose signature appears below, have read a transcript of my participation and agree to its use by the researcher as explained.

(B) Participant's signature……………………………………………………………………………………………Date……………………..

Workshop consent form: Shepparton case study

CONSENT FORM FOR PARTICIPATION IN RESEARCH (workshop)

I ………

am over the age of 18 years and hereby consent to participate in the research project **on Closing the Gap policy implementation and health equity,** which is being conducted under the *Centre for Research Excellence – Health Equity* (*CRE-Health Equity*) funded by the National Health and Medical Research Council.

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I am aware that I should retain a copy of the information Sheet and Consent Form for Future reference.
4. I agree to participate in the workshop and to respect confidentiality of other participants.
5. I am aware summaries of workshop discussions will be documented and stored electronically on a secure server for 5 years after the completion of the project.
6. I understand that:
   - I may not directly benefit from taking part in this research
   - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
   - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential. I understand however that anonymity cannot be wholly guaranteed and that I may be identifiable by association with information in publications arising from the research.
   - I may ask that the recording be stopped at any time, and that I may withdraw at any time from the interview without disadvantage.

Ethical approval for this research has been granted by the Human Research Ethics Committee, GV Health. If you have any concern and would like to discuss or make a complaint about the ethical conduct of this research please contact:

- A/Professor Vasudha Iyengar, Chairperson, HREC, GV Health on (03) 5832 2943 and Vasudha.Iyengar@gvhealth.org.au; or
- Dr Md Rafiqul Islam on (03) 5831 0035 and MdRafiqul.Islam@gvhealth.org.au

(A) Participant's signature…………………………………………………………………………………………Date…………………..

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name………

Researcher's signature………………………………………………………………………………………Date……………………

Interview consent form: Southern Adelaide case study

CONSENT FORM FOR PARTICIPATION IN RESEARCH (by interview)

I ………..

am over the age of 18 years and hereby consent to participate in the research project **on Closing the Gap policy implementation and health equity,** which is being conducted under the *Centre for Research Excellence – Health Equity* (*CRE-Health Equity*) funded by the National Health and Medical Research Council.

8. I have read the information provided.
9. Details of procedures and any risks have been explained to my satisfaction.
10. I agree to audio recording of my information and participation.
11. I am aware that I should retain a copy of the information Sheet and Consent Form for Future reference.
12. I am aware that the recording and transcript will be stored electronically on a secure server for 5 years after the completion of the project.
13. I understand that:
    - I may not directly benefit from taking part in this research
    - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
    - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential. I understand however that anonymity cannot be wholly guaranteed and that I may be identifiable by association with information in publications arising from the research.
    - I may ask that the recording be stopped at any time, and that I may withdraw at any time from the interview without disadvantage.

(A) Participant's signature………………………………………………………………………………………………Date…………………..

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name……

Researcher's signature……………………………………………………………………………………………Date……………………

14. I, the participant whose signature appears below, have read a transcript of my participation and agree to its use by the researcher as explained.

(B) Participant's signature………………………………………………………………………………………………Date…………………..

This project has been approved by the Aboriginal Health Research Ethics Committee (a sub-committee of the Aboriginal Health Council of South Australia Inc: project number 04-16-697, AND by the Ethics Committee from Goulburn Valley Health: project number GV39/16, AND by the Flinders University Social and Behavioural Research Ethics Committee: project number 6786.

Workshop consent form: Southern Adelaide case study

CONSENT FORM FOR PARTICIPATION IN RESEARCH (workshop)

I ……
am over the age of 18 years and hereby consent to participate in the research project **on Closing the Gap policy implementation and health equity,** which is being conducted under the *Centre for Research Excellence – Health Equity* (*CRE-Health Equity*) funded by the National Health and Medical Research Council.

2. I have read the information provided.
3. Details of procedures and any risks have been explained to my satisfaction.
4. I am aware that I should retain a copy of the information Sheet and Consent Form for Future reference.
5. I agree to participate in the workshop and to respect confidentiality of other participants.
6. I am aware summaries of workshop discussions will be documented and stored electronically on a secure server for 5 years after the completion of the project.
7. I understand that:
   - I may not directly benefit from taking part in this research
   - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
   - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential. I understand however that anonymity cannot be wholly guaranteed and that I may be identifiable by association with information in publications arising from the research.
   - I may ask that the recording be stopped at any time, and that I may withdraw at any time from the interview without disadvantage.

(A) Participant's signature……………………………………………………………………………………………………Date…………………..

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name……..

Researcher's signature…………………………………………………………………………………………………Date……………………

This project has been approved by the Aboriginal Health Research Ethics Committee (a sub-committee of the Aboriginal Health Council of South Australia Inc: project number 04-16-697, AND by the Ethics Committee at Goulburn Valley Health: project number GVH 39/16, AND by the Flinders University Social and Behavioural Research Ethics Committee: project number 6786.

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