

**Moving Forward Together in Aboriginal Women's Health:
A Participatory Action Research Exploring Knowledge Sharing,
Working Together and Addressing Issues Collaboratively in Urban
Primary Health Care Settings**

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Summary

This collaborative qualitative research explored ways of improving Aboriginal women's health and well-being in an urban Adelaide primary health care setting. This involved respectful knowledge sharing, working effectively together and addressing issues related to colonisation, discrimination and exclusion. It was identified that while Aboriginal and non-Aboriginal professionals are committed to 'Closing the Gap' in health disparities, many have questioned how best to do so within the current health system. Therefore, this research focused on filling gaps in knowledge about the spaces where Aboriginal community women, and Aboriginal and non-Aboriginal health professionals can work collaboratively *regardful* and *regardless* of health system policies, programs and practices.

A strong commitment to local community preferences and national Aboriginal health research ethics enabled Aboriginal community women and Aboriginal and non-Aboriginal health professional co-researchers to be actively and meaningfully involved with me in both the research processes and outcomes. A modified Participatory Action Research (PAR), with repeated cycles of Look and Listen, Think and Discuss and Take Action emerged as an effective model of collaborative practice, suitable for health care and research.

Four unique yet interconnected areas of collaboration developed, each highlighting particular aspects of culturally safe knowledge sharing and collaboration in health care. The first involved working with Aboriginal community women, acknowledging and addressing *their* most health and well-being priorities related to high levels of stress in their lives. Collaborative action involved creating a women's friendship group, seeking and accessing a range of services, and co-presenting our findings at conferences

The second Collaboration Area offers insights into the practicalities and difficulties experienced by staff as they tried to provide health services for Aboriginal women in a newly developing Aboriginal health organisation. The third Collaboration Area focused on the challenges and benefits of collaboration between sectors, in particular a local high school and the Aboriginal health service. We explored effective ways to work across sectors and engage young Aboriginal women in

health programs. The ongoing impact of discrimination, exclusion and colonisation for this next generation of Aboriginal women was highlighted. The fourth Collaboration Area involved wider collaboration and road testing our collaborative methodology in a broader environment. A diverse group of co-researchers came together to plan, implement and evaluate a de-colonising national action research action learning conference embedded in Aboriginal preferred ways of knowing and doing.

Findings are discussed under the three central themes of knowledge sharing, working together and addressing health care access and colonisation and key recommendations for the future are proposed. This research has reinforced the need identified in Aboriginal health documents for policy, program and practice commitment to holistic and collaborative approaches such as comprehensive primary health care and participatory action research. While the National Apology and Close the Gap campaign have provided opportunities for change, these need to be followed by tangible action at all levels of health care.

Declaration

I certify that this thesis does not incorporate without acknowledgement 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.

Statement of the contribution of others

This thesis has been made possible through the support of many people, including those as follows:

Supervisors

Professor Charlotte de Crespigny, Professor of Drug and Alcohol Nursing, Adelaide University (formerly Flinders University)

Ass Prof Eileen Willis, Head of Paramedic and Social Health, School of Medicine, Flinders University.

Ass Prof Sheryl de Lacey, Associate Dean, School of Nursing and Midwifery, Flinders University

Dr Yoni Luxford, Senior Lecturer, University of New England, (formerly Flinders University)

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Kim O Donnell, Research Associate, Department of Health Management, Flinders University

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Collaboration

A project of this nature in Aboriginal health requires a highly collaborative and knowledge sharing approach. I consulted with many Aboriginal community women, Aboriginal and non-Aboriginal health professionals, researchers and managers. In particular I would like to acknowledge the guidance of the women in the Aboriginal Women's Reference Group.

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Many people, colleagues, friends and family have supported me to complete this thesis and I am truly appreciative of their time, encouragement and advice.

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Terminology

Aboriginal

In this thesis I use the term Aboriginal to describe women of Aboriginal descent. I do not use the term “Aboriginal and Torres Strait Islander” as none of the women involved in this study identified themselves as being of Torres Strait Islander descent, and all preferred that I use the term ‘Aboriginal’.

Aboriginal and Torres Strait Islander

An official title used to describe Australian Indigenous peoples.

Aborigine

A term less favoured by Aboriginal people associated with this research due to its close connection with negative colonisation practices. This word is only used as part of a direct quote from original sources.

Black / Blackfellas

A term that many Aboriginal people use to name themselves in relation to white (non-Aboriginal) people.

Close the Gap

The Oxfam Australia Close the Gap campaign is Australia’s largest campaign to improve Indigenous health. It calls on governments to commit to closing the life expectancy gap between Indigenous and non-Indigenous Australians within a generation (25 years) and is supported by a diverse group of Aboriginal and mainstream organisations across Australia. Specific strategies include increasing Indigenous Australian’s access to health services, addressing critical social issues such as poor housing, nutrition and education, and building Indigenous control and participation in the delivery of health and other services.

Collaboration Area

A method developed in this study to put a boundary around an area of action, and on this bases who will be involved and why. In some ways similar to a case study, but with a specific emphasis on collaboration between co-researchers within a specific area or situation (i.e. working with community women).

Colonisation

In this thesis this refers to past and present actions by Western governments, systems, societies and peoples that have (usually negatively) impacted on Aboriginal peoples.

Community Health

In Australia, Community Health Care refers to health services based in the community, offering more than medical services, funded by government or Aboriginal controlled health services. These services are usually situated close to where people live or work. In South Australia these have focused predominantly on delivering primary health care services.

Comprehensive Primary Health Care

A holistic approach to primary health care that takes into account physical, mental, emotional, spiritual and social health and well-being. It focuses on improvements in the overall health and well-being of individuals and communities and is linked to comprehensive strategies involving curative, rehabilitative, preventative and health promotion activities. Non-medical interventions such as improvements in housing, education, food and environment are considered of high importance.

Indigenous

Originating in a particular region or country. A term often used to describe Aboriginal and Torres Strait Islander people in government documents, but not a term Aboriginal co-researchers wished to be known by.

Kaurna

Aboriginal peoples of the Adelaide Plains (pronounced 'Garna').

Nunga

A term that many Adelaide- based Aboriginal people use to describe themselves.

Postcolonial

The post in postcolonial (used in academic terms) refers to a time after colonisation begins, rather than after colonisation has ended. It refers to a critique, strategy and rethinking about the conceptual, institutional, cultural, legal and other boundaries and assumptions that are taken for granted and assumed universal, but act as

structural barriers to many, including Aboriginal people, women, visible minorities and others (Battiste 2004).

Postcolonial feminist collaboration

Sharing knowledge and working together in culturally safe ways that address issues relating to colonisation, discrimination and exclusion (Kelly 2008)

Primary Care

One aspect of primary health care, that focuses specifically on biomedicine and generalisable approaches to primary health care, for example immunisation programs.

Primary Health Care

A term defined, interpreted and addressed quite differently by people depending on their understanding and intention. Many interpret it to mean the first level of medical care (as in primary care). The World Health Organisation Alma Ata definition is broader and refers to both a service delivery and health care approach that incorporates equitable distribution of resources, community involvement, an emphasis on prevention, use of appropriate technology and involvement of a range of sectors including housing, agriculture and water (Baum 2008; World Health Organisation 2000).

Social Determinants of Health

Social factors that impact on health and wellbeing such as environment, living and working conditions, income, access to services and basic living needs.

Torres Strait Islanders

Indigenous peoples who originate from the Torres Strait Islands between Cape York Peninsula, Queensland, and Papua New Guinea's southern coast.

White / Whitefellas

A term used by many Aboriginal people use to name non-Aboriginal people in relation themselves. Some Non-Aboriginal people (myself included) adopt this term to describe themselves in relation to Aboriginal people, particularly when discussing issues related to colonisation.

Acronyms

| | |
|---------|---|
| ACHSA | Aboriginal Health Council of South Australia |
| AEW | Aboriginal Education Worker |
| AHS | Aboriginal Health Service |
| AHW | Aboriginal Health Worker |
| APHCAP | Aboriginal Primary Health Care Access Program also known as PHCAP |
| ATSI | Aboriginal and Torres Strait Islander |
| ATSIC | Aboriginal and Torres Strait Islander Commission |
| CNAHS | Central Northern Adelaide Health Services |
| FAHRU – | Flinders Aboriginal Health Research Unit |
| GPCC | Gilles Plains Community Campus |
| NECAP | North Eastern Community Assistance Program |
| PHC | Primary health care |
| STI | Sexually Transmitted Infection |

Chapter 1 Introduction

The practice dilemmas that led to this research

This research has developed in response to the practice dilemmas I, and Aboriginal and non-Aboriginal primary health care colleagues have encountered in trying to provide quality health care for and with Aboriginal women in urban settings. I began this research by meeting with Aboriginal and non-Aboriginal primary health care professionals, Aboriginal community and Elder women and other stakeholders (those who influence and are influenced by the research) in the Gilles Plains area of Adelaide¹. During these community consultations we identified which aspects of health care provision we found most concerning. One group of older community women and Aboriginal and non Aboriginal health professionals, identified the following issues.

One Aboriginal health worker began;

In practice, it is really difficult to provide the kind of health care that we know local Aboriginal women want. There are so many conflicting priorities and we just don't have time and resources to do it all.

A non-Aboriginal community health nurse agreed, saying;

It feels like we are throwing the baby out with the bathwater with some of these new changes. There seems to be a lot of short term money thrown at things without any kind of sense of a long term vision about what it takes to make it work, what resources you need on the ground. Each week it feels like there is a new policy and program with new ways of doing things and each of them say 'this one's going to work'.

What we were doing before might have been working perfectly but it is dropped in favour of the new way. And it is all in the name of coordination and consistency, but its contradictory, it is doesn't reflect what we know

¹ Importantly, this process of consultation and inclusion has reaffirmed the right of Aboriginal people to have an integral role in all phases of research that affects their lives and health care. The consultations have directly informed the research development, choice of topics and research methodology.

actually works. There is a lot of local knowledge and resources that get overlooked.

Yes, said one Elder Aboriginal woman who used to be an Aboriginal health worker, if one stays long enough, one sees the same programs cycling around again and again

Another Aboriginal Elder woman added;

Just when we get to know a service, the workers move or get shifted, or the program gets shut down. Then the next one starts and we wonder how long that will keep going, before it is shut down too. It takes us a while to get to know people and services, to trust them. Some of us don't trust easily, too many things have happened to us in the past.

(Gilles Plains Community Consultation, Term 1 2005)

Together we reflected on current health provision trends and whether they were making a positive difference in Aboriginal women's lives. Many of the women in this consultation group were older and had seen a range of policies, programs and practices come and go; some more effective and responsive to Aboriginal needs than others. One commented *it is like being a kangaroo, sitting and watching the passing parade of health care, wondering whether to come out and engage, or stay safely in the distance*. Over the last forty years, a range of policies, programs and strategies have developed across federal and state government sectors and health services, each with their own underlying philosophies (National Aboriginal Torres Strait Islander Health Council 2004). One of the major difficulties for health professionals is finding ways to meet local Aboriginal women's health and well being needs *regardless* and *regardful* of local community, organisational, state and federal policy and program, and practice changes.

The urgent need for effective health care

The urgent need for quality, effective and responsive health care for Aboriginal women and their families cannot be over stated. As highlighted in the 2007/8 'Close the Gap Campaign'² (Oxfam Australia 2007) and the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 (2004),

² Close the Gap – an Australian campaign closing the life expectancy gap between Indigenous and non-Indigenous Australians within a generation (25 years).

although Australia has a world class health service, an unacceptable life expectancy gap of seventeen years between Indigenous and non-Indigenous people continues to exist in Australia today. In addition, Australian Aboriginal (and Torres Strait Islander people³) people experience disproportionately higher incidences of ill health compared to non-Aboriginal Australians, linked to a complex interaction of poorer access to the social determinants of health and past and present discrimination, exclusion and colonisation practices (ANTaR 2008; Oxfam Australia 2007; Rudd 2008). In comparable countries such as New Zealand, Canada and the United States, health and well-being disparities between Indigenous and non-Indigenous peoples have been drastically reduced, but Australia has lagged behind (Australian Health Minister's Advisory Council 2004).

While there have been many improvements in Australia over the last thirty years, unacceptably high health inequalities remain. Successive governments have tried to improve the health status of Aboriginal Torres Strait Islander people through a variety of individual approaches by individual portfolios, operating without the support and partnership of local communities. Many of these have since been evaluated by the National Aboriginal Torres Strait Islander Health Council (2004) as ad hoc, unsustainable programs operating with inefficient use of resources.

The National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 (2004) advocates for a partnership approach that involves Aboriginal and Torres Strait Islander organisations, individuals and communities and a number of government agencies across all levels of government. This approach would be underpinned by concepts of shared responsibility, full collaboration, cultural respect, working together, localised decision making, building capacity, holistic approaches⁴ and comprehensive primary health care. The difficulty for Aboriginal and non-Aboriginal primary health care professionals in urban settings is in knowing how best to implement the strategy, particularly as there is little evidence based and culturally specific information available to guide this work.

³ This research focuses on Aboriginal rather than Torres Strait Islander people. None of the co-researchers identified as Torres Strait Islander.

⁴ Holistic approaches include attention to physical, spiritual, cultural, emotional and social well being, community capacity and governance (NHMRC, 2003).

This research responds to these practice dilemmas by focusing on the ways and spaces that Aboriginal and non-Aboriginal primary health care professionals, Aboriginal community women and stakeholders (families, managers and policy-makers) come together. The specific questions that it addresses are;

- How can health professionals respectfully share knowledge and work effectively with Aboriginal women in urban primary health care services in ways that improve Aboriginal women's health and well-being in meaningful ways?
- Which collaborative models can best assist health practitioners to provide responsive health care for and with Aboriginal women within our complex and changing health system?

The aim of this research was to develop a collaborative approach where Aboriginal women, primary health care professionals and stakeholders could work together toward improving Aboriginal women's health and well being. This was underpinned by strategies of supporting and facilitating Aboriginal women's full participation in all phases of the research, encouraging people to work together in culturally safe and respectful ways and recognising Aboriginal women's right to co-plan and co-evaluate their own health care. Aboriginal community women and Aboriginal and non-Aboriginal health professionals at the Gilles Plains campus and beyond were invited to be involved in this participatory action research as co-researchers.

I, as a non-Aboriginal nurse/researcher, have endeavoured to work in collaboration; listening deeply, supporting capacity building and being open and transparent. I came to this research with an intention to study *among* and *with*, rather than *on*, those around me. I have been mindful of my position and standpoint as a non-Aboriginal researcher conducting this research and have critically reflected on my motivation and beliefs about initiating this research. Using Judy Atkinson's (2006) Indigenous questioning of '*Who are you - mercenary, missionary or misfit?*' I have examined my own background, whiteness and journey of knowledge sharing, collaboration and understanding about the impacts of colonisation, discrimination and exclusions. These reflections are provided as Appendix 1 as encouraged by Aboriginal mentors, who stressed the importance of such information being included.

The thesis

This thesis discusses particular aspects of our collaborative research, written from my own perspective as a non-Aboriginal nurse researcher⁵. Three central themes regarding collaboration emerged and these are; knowledge sharing, working together, and addressing issues. These themes are used throughout this thesis to explore specific aspects of moving forward together. Figure 1.1 below presents these in visual format for those who connect to visual rather than written cues.



Figure 1.1 The three central themes of this research

This visual format is used in the summary of each chapter to reinforce how each chapter relates to, and expands on, these central themes

The writing style and structure of this thesis reflects the importance placed on collaboration and challenging Western colonisation trends. Aboriginal Elder women from the Aboriginal Women's Reference Group strongly argued that to write two separate documents, one for community and one for examination, would be seen as taking Aboriginal knowledge and repackaging it in ways that are no longer accessible to community; another act of colonisation. In recognition of these women's previous experiences of having their cultural knowledge taken and publicly ridiculed, and the trust they placed on me not to do this again, I sought ways that I could meet both their cultural need for a transparent and readable text, and my need to create an academic text suitable for PhD examination. In a pragmatic sense, I believed both *were* possible, and in fact *had to be* possible for this to develop into a highly respectful, ethical and collaborative research project. I, and most of the co-researchers, regarded the Aboriginal Women's Reference Group cultural guidelines as important as the university's academic guidelines. This was

⁵ If any of the co-researchers were to write about our collaborative research, it would be different. It would reflect their particular emphasis and priorities.

the reality of conducting a collaborative community based research as a PhD student.

As researcher and author, I endeavoured to maintain a delicate balance between respectfully acknowledging the words of Aboriginal and non-Aboriginal co-researchers through the use of quotes (in italics) and maintaining their confidentiality and protecting their identity through the use of coding and themes. The approach taken in each instance reflects co-researchers own preference for public acknowledgement or the need to remain anonymous.

The literature review sections of this thesis include both oral and written sources in recognition that much Aboriginal knowledge remains unwritten. The community consultation that took place as preparation for this research forms a significant part of this oral knowledge. When choosing written texts to discuss colonisation and Aboriginal experiences of health care, I have devised a hierarchy of texts that prioritised those written by Aboriginal authors, then those written collaboratively between Aboriginal and non-Aboriginal authors, and then those written by non-Aboriginal people are considered an accurate account by Aboriginal co-researchers and mentors.

Structure of the thesis

The structure of this thesis is also purposeful and reflects a blending of both academic and Aboriginal co-researcher and reference group priorities. Chapter Two presents an overview of Australian colonisation and associated discrimination and exclusions and the impact this had, and continues to have, on Aboriginal women and their families, leading to current health disparities. Examples of non-collaborative approaches central colonisation practices and the associated impacts of social, gender, economic and environmental issues are highlighted.

Chapter Three explores the development of primary health care, Aboriginal health and women's health as the three main components of Aboriginal women's health care in community health settings in urban Adelaide. Significant changes in each of these areas over the last forty years have led to a diverse and at times confusing range of experiences, expectations and concepts relating to knowledge sharing and collaborative action by both health professionals and Aboriginal community women clients. This chapter provides a discussion of the various and changing policies and

practices that have led to specific expectations and experiences discussed by Aboriginal women and Aboriginal and non- Aboriginal health professionals in specific Collaboration Areas of this research.

In Chapter Four I provide a deeper discussion about the concepts of respectful two-way knowledge sharing, collaborative action and postcolonial feminist theory that underpin this thesis and research. I begin by explaining Western concepts of communication and knowledge interests, and Aboriginal concepts of Ganma two-way knowledge sharing across cultures and Dadirri deep listening. Issues that can prevent or interrupt respectful knowledge such treating people as ‘Others’ and needing to understand and work with cultural understandings and different cultural understandings are highlighted. Considering these aspects together enables a broader concept of knowledge sharing suitable for Aboriginal women’s health care settings. The second section explores how knowledge and power sharing can lead to collaborative action. The concept of liberation and community development is based on the idea people can be supported to improve their life situation, health and well being. The third section discusses the use of postcolonial feminism to counter colonisation, discrimination and exclusion. In particular, a combination of postcolonial theory and feminism enables health professionals to provide culturally safe care that meets clients’ own needs. A recognition of a range of knowledges as being valid in evidence based practice enables health professionals to utilise subjective professional, client focused and cultural knowledge and priorities as well as external and objective biomedical / technical knowledge. I begin by discussing knowledge sharing as the building blocks of collaboration and culturally safe health care.

Chapter five discusses the ethical approach and methods used in this research, chosen in consultation with co-researchers. I explain how Aboriginal health research ethics have been used to guide this research, and then discuss how we co-created an appropriate participatory action research approach to specifically meet co-researchers needs. A range of methods including literature and document review, semi structured interviews and focus groups guided by trigger questions, and the analyses of emerging themes were used. Repeated cycles of Look and Listen, Think and Discuss and Take Action enabled us to explore ways of addressing Aboriginal women’s health and well-being priorities at one urban

community health site. Four different Collaboration Areas of research activity were developed and these focused on local Aboriginal community women's needs, the newly emerging Aboriginal Outreach Health Service, collaboration with the local high school, and the creation of a decolonising conference for improved knowledge sharing.

The specific research context is outlined in Chapter Six. The Gilles Plains Community Campus is a site of mainstream and Aboriginal-specific primary health care in the North Eastern suburbs of Adelaide, South Australia. It is also the site where most of our community based participatory action research took place for this study. An important aspect of this research has involved understanding how health services and relationships between people develop, and what affects this development. In this chapter I discuss the history of the Gilles Plains Community Campus, highlighting the policy and health systems changes and factors that have impacted on community participation, community development and comprehensive primary health care provision.

The first of the four Collaboration Areas begins with Chapter Seven. This chapter discusses how four Aboriginal community women and I worked together as co-researchers to address *their* most pressing health and well-being needs. We co-created collaborative participatory action research, enabling the women's perspectives to be heard and acknowledged. I supported the women as they identified options and initiated actions amidst and in response to changing community health and Aboriginal health policies and priorities. Both processes and the outcomes of this Collaboration Area are intricately entwined and discussed as they occurred within each research cycle. The women's own thematic analysis was placed within *think and discuss* phases. My additional nurse/researcher analysis is presented at the end of the chapter.

In Chapter Eight I offer insights into the practicalities and difficulties experienced by staff as they tried to provide health services for Aboriginal women in a newly developing Aboriginal health organisation. This chapter discusses how we further developed and tested our model of collaborative practice to complement rather than complicate work loads and organisational directives. We began by discussing a broad vision for Aboriginal women's health and well-being (*look and listen*), and then what was currently possible with the resources available. Health staff raised

concerns and challenges (*think and discuss*) and together we planned strategies to address the gaps and needs. Our collaborative action (*take action*) involved mapping available resources, holding Women's health days, and involving young Aboriginal women in programs. This chapter provides another perspective on many of the issues raised by Aboriginal community women in Collaboration Area One.

The focus in Chapter Nine is on health and well-being needs of young Aboriginal women. Although originally I intended to work directly with young Aboriginal women at the Gilles Plains campus, this did not eventuate for a range of complex reasons. Rather this Collaborative Area focused on how Gilles Plains Aboriginal Outreach Health Service and the local high school, Windsor Gardens Vocational College, could work together to improve young Aboriginal women's access to health information, services and well-being.

In Chapter Ten I outline how co-researchers and I developed a collaborative decolonising action research and action learning conference embedded in Aboriginal preferred ways of knowing and doing. This Collaboration Area emerged as a way to address Aboriginal women co-researchers' concerns about the limited opportunities they had to share and have their own personal and professional knowledge heard, valued and respected. I also had ethical concerns about writing this thesis and presenting my account of our collaborative research, without first creating spaces for co-researchers to share their own knowledge with a wider audience. A group of Aboriginal and non-Aboriginal researchers, academics, educators, project managers and other interested people came together to co-plan and co-host a national conference in Adelaide titled 'Moving Forward Together'. Both the process and outcomes are discussed as equally important aspects of this research. The thesis is brought together in the final Chapter Eleven.

Chapter two introduces the theoretical framework that underpins this research, and outlines how Aboriginal and Western concepts of knowledge sharing and collaboration are brought together to form the guiding philosophy.

Chapter 2 Aboriginal Women's Experiences of Colonisation, Discrimination and Exclusion

To understand and meet the goals of collaboration and knowledge sharing it was necessary to first explore and comprehend Aboriginal experiences of colonisation. This chapter highlights those aspects of colonisation, discrimination and exclusion that impacted, and continue to impact on Aboriginal women's daily health and well-being. In community consultations Aboriginal participants voiced their perception that many non-Aboriginal South Australians, including health and research professionals, have little understanding of the extent that past and present colonisation practices, social, employment and economic exclusion and personal and institutional discrimination impact on Aboriginal women and their families (Community consultations 2005).

In this chapter I argue that a set of dominant ideas popular in Europe in the 18th and 19th centuries continued well into the 20th and 21st centuries and are reflected in government policies and practices up to the current times. An elective affinity existed between the ideas of Development outlined by Locke, Rousseau and Darwin, and European expansion into the new world that allowed the robust development of capitalism based on exploitation. These ideas came together allowing Europeans to take over the land and resources of Native peoples. In the next section of the chapter I outline a range of policy ideas from segregation to self-determination illustrating the way in which these policies continued to exclude Aboriginal people. In outlining the various policy eras, I draw specifically on written work or research by Aboriginal women who have reflected on the impact of government determinations on their lives. I make two arguments, firstly that Aboriginal women carry this legacy of colonisation, and its continued practice as part of a collective trauma, and secondly, that policies and practices were instituted without collaboration or communication with Aboriginal people. I draw heavily on texts that have Aboriginal authors or co-authors and have been 'approved' as *authentic* and a *good representation* by Aboriginal co-researchers, stakeholders and mentors. I also draw from specific South Australian texts written by non-Aboriginal authors, with Aboriginal people verifying that from their experiences and conversations, these accounts can be considered valid. Interwoven with the written

texts are Aboriginal women's stories shared through the community consultations that are recognised as an oral form of Aboriginal knowledge.

Contemporary experiences

Although non-Aboriginal people may or may not be aware of the impacts of colonisation, most of the Aboriginal women that I spoke to in the consultations identified it as an everyday occurrence in Adelaide today. Many suggested that until issues related to colonisation, discrimination and exclusion are acknowledged and addressed, Aboriginal women's health and well-being, and increased access to and experiences of health care, will not significantly improve (Community consultations 2005). One Aboriginal health professional described the process that she follows in group programs to counter these issues. She said

the importance of providing transport is so that young women do not need to face racism on the way to the workshop/session. And we meet them at the front door, so they are met by a smiling face instead of being ignored or frowned at by others in reception. That way their whole day can be positive. She continued, if they could experience one day where they felt safe, respected, loved and accepted that would be a great outcome (Community consultations 2005).

Throughout the community consultations (2005) Aboriginal women spoke of personal or family intergenerational effects of low or no wages resulting in poverty, ongoing exclusion from mainstream society, and the degradation of being treated as second class citizens. Some described colonisation as *a negative thread running through our lives, overshadowing everyday events*. Many discussed personal or shared memories of past harmful events involving hospitals and health care that continued to influence their decision whether or not to access services. One woman shared her first experience of women's health care;

I had my first baby young. We were in the hospital waiting to take the baby home, and the nurses seemed to be taking a long time. Mum waited for a while. She was watching out the window and listening up the corridor, worried about why it was taking so long. Suddenly she said 'quick jump out the window here with the baby, they are planning to take her away'. We got in

the car and drove all day and all night. We went interstate where they couldn't find us, so they couldn't take my baby away (Community consultations 2005).

Most Aboriginal women I have spoken with have a personal or family story of being refused service in a shop, being abused by strangers as they walk down the street, watching their parents being demeaned by government officials, being taken away from their families, or watching siblings being taken away. Over time we began to question;

How did it come to be like this? Why are these issues still so bad in Australia compared to other countries like New Zealand? And what about in South Australia, are Aboriginal experiences the same or different to those of Aboriginal people living interstate? (FG 1- 4 discussions)

To begin addressing these questions, I have explored the different concepts of knowledge, culture and society held by Aboriginal Traditional people and European people and what happened when they came together. When the two groups came together, they had such different ways of experiencing and knowing the world, that understanding, knowledge sharing and collaborative action rarely occurred. Add to this the incoming European intention to take over other people and their land was assured. What particularly concerns me and the women I work with, is the extent to which this history (consciously or unconsciously) continues to permeate health care access, provision and experiences today.

Two vastly different cultures on opposite sides of the world

Australian Aboriginal culture

Australian Aboriginal peoples are believed to be one of the oldest civilisations in the world, having lived in Australia for between 40, 000 to 70, 000 years or since the beginning of the Dreaming (Morrissey & Fricke 2001). Across the continent Aboriginal groups lived in a diverse range of locations, from lush tropical rainforests, to mountain ranges, coastal areas, river systems, deserts and grasslands. Each Nation had varied tribal groups and each had their own unique culture and language as well as general similarities with other Aboriginal peoples. Tribal boundaries were clearly identified by land forms and Dreaming stories. Trade,

social contact and occasional conflict between nations, tribes and groups were governed by very strict rules of engagement (Eckermann et al. 2006).

Most Aboriginal nations shared (and continue to share) fundamental similarities involving oral and experiential knowledge passed down the generations through art, ceremonies, story telling, a deep spiritual connection to the land, a strong belief in the Dreaming and very sophisticated kinship structures (Eckermann et al. 2006). Many Aboriginal people held (and continue to hold) a community world view that firmly connects individuals, families and the land around them, as one. Clearly designated spiritual, cultural and teaching roles were based on gender, described in South Australia as *Men's Business and Women's Business* (Aboriginal Women's Reference Group 2005; Morrissey & Fricke 2001). Work followed gender roles with men hunting larger animals and women gathering smaller animals and local plant based foods and caring for younger children. High protein diets, fresh foods and frequent exercise ensured that most Aboriginal people had healthy body weight ratios and strong physical bodies. Concepts of health and well-being included spiritual and collective well-being and harmony (Aboriginal Health Council of South Australia & South Australian Health Commission 1994). Children were considered an important part of community life, and were taught skills and responsibilities by adult members of the community as part of every day activities. Ceremonies and stories were used to teach specific aspects of social life, spirituality and lore (Community consultations 2005; Eckermann et al. 2006; Mattingley & Hampton 1998).

Prior to colonial invasion, over forty independent Aboriginal tribal groups lived in the coastal areas, fertile plains, hills and deserts of what is now known as South Australia. Each group had their own clearly defined territory 'held in sacred trust from generation to generation, and respected by [Aboriginal] outsiders' (Mattingley & Hampton 1998, p. 3). Each community had their own specific language and culture, religion and laws, with some similarities between groups. For example Kaurna and Ngarrindjeri women co-researchers in this study discussed the weaving of baskets, mats, and water carrying vessels in both of their communities. Each cultural group wove in a distinct pattern, and many stories were shared between women during the weaving (Aboriginal Women's Reference Group 2005).

British and European culture 1600s – 1800s

Society and culture developed somewhat differently in Britain and Europe. Overriding the differences and individuality were a series of events and beliefs that governed the way Western culture developed from the 1600s through to the late 1800s. At this time, citizens of Europe and Britain experienced rapid social, economic and cultural changes linked to increased industrial development, the rise of capitalism and empire expansion (Ashcroft 2001a). Close knit rural communities with local rulers and practices were replaced with urbanised, industrialised, material based living, where people were encouraged to work hard, achieve and be involved in development. Through out these changes, the class structures of working class poor and wealthy aristocracy were held in place and a new class consisting of wealthy industrialist and middle class industrialists, bankers, merchants and traders emerged. Off shore colonial activities such as exploratory voyages and the sugar, tea and slave trade, assisted in building the capital of Europe.

Postcolonial authors Ashcroft (2001a) and Said (1993) suggest that the rich English gentry and Britain's 'civilizing mission' were built upon the exploitation of working class poor within England, and the exploitation of people and resources in outer colonies such as Africa. By 1914 Europe claimed roughly 85% of the globe as colonies, commonwealths, dominions and dependencies (Said 1993, p. 6). A set of beliefs about life, knowledge, race, class, capitalism and development supported these activities.

Western science, literacy and concepts of dominance

Western scientists and philosophers attempted to explain evolution and why various cultures and races developed differently across the globe. Scientists such as Charles Darwin created a concept of '*the Great Chain of Being*', in which all life was arranged in a hierarchy, from the simplest to the most complex (Eckermann et al. 2006, p. 8). This epistemology (way of thinking about the world) described humans as being arranged from the most primitive to the most civilised, placing white Europeans at the top of the hierarchy. Hundreds of research papers were written, speculating about the biological, cultural and spiritual qualities of non-Europeans further down the chain. This 'science' fed European assumptions and stereotypes about Indigenous cultures. Australian Aboriginal and other Indigenous peoples

were envisioned as the missing link to the pre-historic past; lesser humans who lived a static culture, and who were child like, unpredictable, immoral, and Godless. As such they were considered less than human, not requiring the same considerations as ‘civilized’ British subjects (Ashcroft 2001a; Eckermann et al. 2006; Said 1993).

Europeans developed their identity by comparing themselves to how they perceived ‘other’ races, cultures, religions, and geographical environments and economics systems to be. They determined that what they did was normal, and that all other races were in a state of aspiring to become like them. Although there was some debate about this dominant ideology, the influence of those who disagreed had a minimal effect (Ashcroft 2001b; Said 1993).

Alongside capitalism and Western ideology, literacy and formal education became linked with intelligence, particularly when print material enabled literature to become more widely available (Ashcroft 2001b; Said 1993). Those who were ‘educated’ took the role of the instructing, monitoring and correcting of those who were not. Around the same time, the concept of ‘the child’ also emerged in European thinking. Children were illiterate and therefore considered to be unknowing and uneducated; having the potential for good yet being inherently evil (Ashcroft 2001b). Locke (1693) theorised that children at birth had a mind that was like a blank slate, and it was the responsibility of parents and schoolmasters to ensure that appropriate literacy, education, reason, self-control and shame were written onto the mind to ensure a ‘civilised adult’ emerged. This followed the puritan belief that *‘though his body be small, yet he hath a [wrongdoing] heart, and it is altogether inclined to evil’* (Ashcroft 2001a, p. 39).

In comparison, Rousseau envisioned the unformed child as possessing capacities for candour, understanding, curiosity and spontaneity which must be preserved or rediscovered. While there were obvious tensions and contradictions between these two viewpoints, together they formed the justification for the need for education and civilising processes for children by paternalistic and authoritative figures. Class also impacted on how children were treated by adults, with upper class children well cared for and lower class children often placed in slavery (Ashcroft 2001a).

Prominent Western theorists then drew links between ‘the child’ and ‘primitive’ races. Renan for example, suggested that philosophers needed to understand the child to understand the savage. He encouraged investigators to *travel among the primitive peoples which are fast disappearing from the face of the earth* (Renan 1891, p. 150). Likewise, Darwin’s theory of evolution helped to cement the idea that the child and ‘the savage’ were at an interchangeable stage of evolution (Ashcroft 2001a).

Victorian travellers’ and explorers perpetuated the idea with travel diaries full of their perceptions of Indigenous peoples as being childish, immature, and primitive, dangerous, unbridled pre-civilised savages lacking any sexual restraint. In 1872, Richard Burton described tribesmen of East Africa as *the slaves of impulse, wilful passion and instinct* (Burton 1872). Similarly Lionel Phillips described South African ‘Kaffirs’ as *‘a complex mixture of treachery and cunning, fierceness and brutality, childlike simplicity and quick wittedness’* concluding that *‘such people require a master, and respect justice, and firmness. Generosity is a quality they do not understand’* (cited in Bolt 1971, p. 137). These travel diaries and travellers tales appeared to confirm the science and became unofficial but influential anthropological accounts (Said 1978, 1993).

The concept of ‘development’ as a maturation or growth linked to progress, science and intellect also emerged in the eighteenth century. Post-colonialists⁶ argue that this strengthened the belief that children and ‘primitive’ people were less developed and therefore required authority, meaningful direction and education (Ashcroft 2001a; Locke 1693). The combination of nineteenth century scientific belief in the hierarchy of man and superiority of European knowledge, with children and primitive man being viewed as similarly undeveloped and uneducated and requiring authority and direction, and supportive evidence of lesser species from overseas travellers and explorers, all led European Imperialists to adopting a belief that they had the authority, right and ability to colonise land belonging to others (Said 1993, p. 121).

When emerging scientists came to Australia (as well as Africa, Asia, New Zealand, Canada and the Americas) they brought with them tools of Western analysis and an

⁶ The concepts within postcolonial theory are explained more fully in chapter four.

array of images, notions, and quasi-scientific concepts about barbarism, primitivism and civilisation. Armed with anthropology, Darwinism, Christianity, utilitarianism, idealism, racial theory, legal history, linguistics and the lore of intrepid travellers, they maintained and affirmed the superiority of English civilisation (Said 1993, p. 121). The result was cultural clash.

Colonisation - the cultural clash that led to losses

Colonisation had the same impact for Indigenous Australians, as a meteor hitting the earth - total devastation (Shen 2006)

Two main factors determine whether two different cultures will connect or clash when they come together. Eckermann and colleagues (2006) describe the first factor as the extent in which the two cultures recognise each other as human beings, and the second, whether the two groups share, or believe that they share, similar values and beliefs. When people look alike and have similar behaviours cultural clash is less likely. If the two cultures are quite different however, there is increased risk of intolerance, suspicion and misunderstandings (Eckermann et al. 2006; McConnochie 1973). If one group also holds a strong belief that they are superior, and that they have the moral, political and religious right and ability to take over the lives of the other group, cultural clash is inevitable. This is the main theme running through the story of Australian colonisation. While there have been some instances of knowledge sharing and collaborative action, the overall experience for most Aboriginal people has involved pain, inequities, discrimination and/or exclusion⁷.

Loss of identity - Terra Nullius the land of no one

When Captain Cook sailed to Australia in 1788 he found a continent unmarked by signs of Western civilisation or European style agriculture, settlements or

⁷ In this next section I discuss policies and practices from across Australia, and more specifically South Australia, that have affected Aboriginal women's health and well-being. Where possible I have included the perspectives of local Aboriginal people through assisted biography texts such as *Survival in our own Land*; *Aboriginal experiences in South Australia since 1836 - told by Nungas and others* (Mattingley & Hampton 1998) and *My side of the bridge* (Brodie & Gale 2002). In respect of Auntie Veronica Brodie's unique relationships to many of the co-researchers, stakeholders and myself, I refer to her in text as Auntie Veronica Brodie in text, instead of Brodie, which seems somehow disrespectful. Auntie Veronica passed away in 2007 and permission has been sought from her family and peers to use her name in this thesis, at this time.

government and claimed the whole continent as uninhabited crown land. This action was supported by a European political belief that;

When the Nations of Europe, which are too confined at home, come upon lands which the savages have no special need of and are making no present and continuous use of, they may lawfully take possession of and establish colonies in them (De Vattel 1758 in Eckermann et al. 2006).

Totally ignoring the 500 or more different Indigenous nations already living in Australia, Australia was declared terra nullius, an empty land owned by no one⁸. This action went against every other European colonising activity since the 1600s, all of which involved some level of treaty negotiation (Eckermann et al. 2006; Morrissey & Fricke 2001).

Loss through frontier violence, illness and displacement

Please note: these following paragraphs may be particularly distressing to read.

Invasion and frontier wars began in Australia with the first settlement in Sydney in 1788, and then continued throughout Australia well into the mid 1840s as Western settlement spread⁹. Frontier wars between Aboriginal and non-Aboriginal people were fairly evenly pitched until diseases, the repeater rifle, and the Native Police were introduced (Broome 2002; Eckermann et al. 2006). Estimates of how many Aboriginal people lived in Australia pre-colonisation, and how many died post-colonisation, vary greatly. Lancaster Jones (1970) suggests that between 1788 and 1947, 50 – 90% of the total Aboriginal population perished during the immediate stages of colonisation. With the arrival of white men on horses came brutal accounts of poisoned water holes, massacres and shootings, with whole tribes being slaughtered (Eckermann et al. 2006). Aboriginal women have told numerous stories of horrifying violence against themselves and their families. One Aboriginal survivor told historian Jan Roberts;

⁸ As described by Ashcroft (Broome 2002; Eckermann et al. 2006) links were drawn between Locke's concept of the child's mind as a blank slate needing to be guided by an authoritative and knowing parent and the assumptions made by Imperial explorers and colonisers that 'undeveloped countries' like Australia (both people and land forms) were a blank slate waiting for a more intelligent and developed group to come and take over.

⁹ In the Coorong area of South Australia, the Milmenrura people carried out resistance activities in the early 1840s, raiding stations and settlements, in groups of up to 300 warriors. As a result, several military detachments were sent against them at this time (Peoples Health Movement 2008).

My mother would sit and cry and tell me this: They buried our babies in the ground with only their heads above the ground. All in a row they were. Then they had tests to see who could kick the babies' heads off the furthest (Roberts 1981).

Whalers and sealers who were the first to come to South Australia, stole Aboriginal women from South Australian and Tasmanian communities taking them to other remote coastal areas. As colonisation spread, so too did the exploitation of Aboriginal women, and the violence toward their families who tried to protect them or retaliate. Aboriginal women as young as eight were victims of rape and exploitation. Aboriginal women were often regarded as 'playthings' for the white men across Australia (Atkinson 2002). They suffered high rates of sexual assault, sexually transmitted infections, and pregnancies, mostly from the white men. Gonorrhoea was common and many babies were born with serious vision impairments (Duguid 1972).

Such highly disturbing colonial events are rarely discussed in mainstream Australian society. In comparison, many Aboriginal people continue to feel a deep connection to these past experiences. Judy Atkinson in her book *Trauma Trials* discusses the ongoing collective inter-generational trauma experienced by Aboriginal people today through oral stories, spiritual connections and Dreaming (Atkinson 2002). Older Aboriginal women in Adelaide discuss where massacres and hangings took place in and around Adelaide, and say that these places still feel unsettling and *cold* today (Aboriginal Women's Reference Group 2005; Brodie & Gale 2002).

Adding to the rapid decline in Aboriginal population numbers were illnesses and deaths due to introduced diseases such as small pox, influenza, whooping cough, measles and sexually transmitted infections. These began to impact first along coastal and river travel routes, and then spread inland as settlers and explorers progressed across the land. Auntie Veronica Brodie discusses the impact on the Kurna community in the Port Adelaide area;

All the land along the coast to Outer Harbour and along the Port River was Kurna land. They call it Yerta Bulti which means land of the dead or land of grief because a lot of Kurna people in this area died from the small pox,

which reached this area even before South Australia was officially made a colony. The virus came along the Murray River from the eastern states, and it wiped out a lot of Kurna people (Brodie & Gale 2002).

This illness struck Aboriginal people who had no immunity for such illnesses.

Aboriginal people across Australia became displaced from their lands to make way for townships, agricultural and farming areas. By 1860 there were 20 million sheep in Australia, destroying waterholes and grasslands. Settlers killed kangaroos to protect the grass for sheep and cattle, and when Aboriginal people who relied on this food source killed livestock for food, they were then punished or killed by settlers and law makers (Morrissey & Fricke 2001).

The declaration of terra nullius had serious repercussions for Australian Aboriginal peoples. Unlike Indigenous peoples in nearby New Zealand/ Aotearoa, Australian Aboriginal (and Torres Strait Islander) people did not, and do not, have a treaty to negotiate land rights, equitable social and health care and basic human rights (Baum 2008; Consedine & Consedine 2005; Eckermann et al. 2006). Connection to tribal land has always held physical, social, emotional and spiritual significance for Aboriginal people, and in today's Western society, land 'ownership' is linked to personal, social and economic determinants, rights and benefits. Internationally the recognition or return of Traditional land to Indigenous people is seen as a vital step towards an improvement in overall health, identity and well-being. While some progress has been made in this area, much is still to be done (Oxfam Australia 2007).

South Australia- a humanitarian colony?

South Australia has both a similar and a slightly different colonial history to the rest of Australia. Unlike other states with penal colonies, South Australia (and Northern Territory) was designed to have no convicts, only free settlers. There were high hopes among progressive reformers in England that liberal ideas of social reform, humanitarian ideals and freedom would enable Aboriginal people to assimilate and become an intrinsic part of South Australian society (Gale 1972). In 1834 Governor Hindmarsh proclaimed that any one who mistreated 'Aborigines' would be

punished, and that Aborigines would be supported to advance in civilisation, and convert to the Christian faith (Gale 1972).

Unfortunately, the reality of colonial experiences within South Australia became very similar to that of other states. With strong European values, settlers began imposing their own beliefs, such as preventing Aboriginal people from bathing in the River Torrens (Karrauwirraparri), holding corroborees on Sundays, or have unrestrained dogs (Mattingley & Hampton 1998). The new colony had three conflicting aims. The first was to assimilate Aboriginal people into western ways of being, the second was to treat Aboriginal people humanely and fairly, and the third was to promote the commercial success of the new land venture for free (white) settlers. These three aims were incompatible. In relation to humane and fair treatment and land settlement, early colonial instructions were that;

‘No lands which the Natives may possess in occupation or enjoyment be offered for sale until previously ceded by the Natives to the Commissioners’ (instructions to Governor Gawler by the Colonisation Commissioners in Gale 1972, p. 39)

However, such treaties and bargains were rarely made. Reserve land put aside for Aboriginal people was retaken. Settlers with land and pastoral interests expanded their hold on South Australian land, gradually moving across the state. Ex-convicts and settlers from interstate moved into South Australia seeking un-claimed land. The concept of ‘un-used land’ reflected Western cultural concepts of development and failed to recognise Aboriginal people’s seasonal movement within their lands. From an Aboriginal perspective, there was no unused or unclaimed land (Mattingley & Hampton 1998).

A local Elder woman’s recollection

Auntie Veronica Brodie recounts her family’s experiences in the Port Adelaide / Glanville area, illustrating the ongoing impacts of colonial spread. She says;

My grandmother took me up to Glanville at the age of eleven or twelve. She said I will show you the site where we were kicked off our land. So my mother, my grandmother and myself went up to Glanville. We walked up the road to the wharf and onto that site. Then she stood outside the CSR factory and shook her fist at it and told us how much she hated it.

I said Grandmother why do you hate it so much? And she said 'you don't know what that factory did to our people. What those people did, it left us as nothing!'

As I got older she explained that her Mothers' old campsite was where the Jervois Bridge is now, about midway across the bridge, where the Hawker River used to flow into the Port River. Lartelare's campsite was there. The site was flooded out when the river was widened, so she moved her campsite over to where the sugar factory was built.

When my grandmother reached the age of fourteen years, the government sold or leased the land where Lartelare camped because it was Crown land according to British law. The CSR Company thought it would be a very convenient place to put a sugar factory, because it was on the Port River and the boats could come and take their sugar away. My grandmother and her family had no papers to prove that the Glanville land was theirs. So what could they do? They had to get up and move. They had to carry what little they had and find somewhere else to camp.

So they walked from the Glanville site all the way to the city, Grandmother and her younger brother James, and Great grandfather and Great grandmother, and her older brother. They walked to the East parklands. The police arrested them there. You can go back to the police records and see that in 1890 Laura was arrested in Adelaide with her mother and father and younger brother James. That was after they were kicked off their land at Glanville and had to walk through to Adelaide, begging for food, money and whatever they could get.

They eventually headed for Victoria Square (in the centre of the city), which was a very old popular camping place for Aboriginal people called Tarndanyangga. But it was full, so they had to go south to Glenelg to the foreshore camp there. So for a number of years Grandmother lived with her family at Glenelg, but the land at Glanville still meant a lot to them. They would walk back to see it, but the anger always used to get the better of them. They used to go away feeling really bad about what happened.

The police didn't like it when Aboriginal people stayed around Adelaide. They kept trying to get Grandmother and her family out of town. The police arrested them for being 'idle and disorderly' and gave them twenty-four hours notice to leave, but a month later they were back again.

Kurna people were taken from Adelaide and shipped out to different missions such as Poonindie on Eyre Peninsula, Point Pearce to the north, or Raukkan in the south. They lost what was their land and many of them just roamed around. Some went as far as Tasmania. Just a short time ago I received a letter from a woman saying that her father's grandfather could remember the very last of the Kurna people being shoved onto trains at Semaphore and being taken away to live elsewhere. It is just like the Jews were shoved onto the trains in Germany, Aboriginal people were taken away in the old box cars (Brodie & Gale 2002, pp. 9 - 11).

Auntie Veronica goes on to explain how she chooses to live in the area around Glanville because it means so much to her. She tried living elsewhere but she *just had to come back to the Port*. She describes getting a certain feeling when she walks at Glanville, feeling the spirits and knowing this was Lartelare's campsite. In 1995 she made a claim for the land, dreaming of an Elder village or cultural interpretation site there. A fire at the CSR factory had led to it being dismantled. Unfortunately the land was badly contaminated with arsenic and the clean up bill was estimated to be a million dollars (Brodie & Gale 2002). She continued to have discussions with the Port Adelaide Council until she passed away in 2007. She said that she did not want to have the land for herself, but for her community, black and white.

The roller coaster ride of land rights

Auntie Veronica's journey is repeated in many times and places across Australia. There have been many attempts to address Indigenous land ownership in Australia, with limited success. The two most significant legal and political debates regarding land rights of Australian Aboriginal people in the last few decades are known as 'Mabo' and 'Wik'. These national court hearings have been watched closely by many Indigenous peoples and their supporters, and are seen as an indication of where Australia is situated in relation to colonisation practices and the return of

land to Indigenous peoples (Aboriginal Women's Reference Group 2005) (Aboriginal Legal Rights Movement 2008) These accounts highlight the collaborative work of Aboriginal and non-Aboriginal people attempting to address past colonisation practices (what is possible), and the strong colonial resistance that continues to permeate our legal and political systems in Australia (the barriers).

Mabo and Wik

In the 1980s a group of Torres Strait Islanders led by Eddie Koiki Mabo began legal action to have traditional title to their land on Mer (Murray Island) formally recognised. Eddie Mabo had been refused permission by the Department of Aboriginal and Islander Affairs to visit his family on Murray Island. He believed he had the right to return as it was his homeland. A legal team determined that Mabo and other Meriam people had a strong case to argue Native Title as it was clear that they could prove uninterrupted occupation of their land, due to visible and lasting signs of soil cultivation (Attwood 1996). The resulting 10 year court case was long, difficult and protracted. Repeatedly the legal system discredited the oral, family and traditional knowledge of the Meriam people. This was a culturally unsafe process for those involved (Morrissey & Fricke 2001; Ramsden 2002).

Eventually the legal team successfully challenged the concept of terra nullius in the Australian High Court. Unfortunately Eddie Mabo and two other Meriam members died before the final High Court decision was handed down in 1992. The Mabo decision, as it became known, was hailed by some activists as a positive step forward in reconciliation. Others saw it as an ambiguous decision, and one that did not outline to what extent Native title existed on mainland Australia (Morrissey & Fricke 2001).

In 1997 the Wik people challenged the Queensland Government over Native Title and pastoral leases granted to graziers by the crown. Native title, a concept based on the idea that Aboriginal 'owners' of the land need to be able to prove a continual connection with their traditional lands is easily extinguished in situations where Aboriginal people have left the land voluntarily or forcibly. Government policies and takeover of land for purposes such as pastoral, mining and townships have left few Aboriginal people in a position to claim continual connection (Morrissey & Fricke 2001; Norberry 1997). The Wik People versus the Queensland Government

case found that Native title was not extinguished by pastoral leases granted to the crown by graziers, meaning that Aboriginal and Torres Strait Islander could still access these lands. However, the Commonwealth Government quickly legislated against the Wik judgements, negating any positive advances for Aboriginal peoples (Baum 2008).

Aboriginal Elder people like Auntie Veronica Brodie have watched the national legal battles unfold over the years. For some it offers a glimmer of hope, for others it reinforces the colonial power that the Australian Government still holds and wields over Indigenous peoples of this country (Community consultations 2005). Elder women have discussed that *as we get older, we have to make decisions about how much energy we can put into continuing such battles, we are getting tired and our health is not so good* (Aboriginal Women's Reference Group 2005). Mabo died before the final ruling was made in his favour (Morrissey & Fricke 2001). Similarly, Auntie Veronica had the only inner city suburb land claim in South Australia, but became increasingly ill and passed away before she could progress the claim. These battles have taken place within a landscape of specific government policies and strategies offering differing levels of self determination and collaboration.

Surviving the impact of Government policies

Welfare and missions: safe or stifling

Another conflicting aspect of colonisation involves welfare and missions (Community consultations 2005). Less than 10 years after the foundation of the South Australian colony in 1836, most Aboriginal people had become dependent on the state's welfare systems through loss of land and food supply, poor nutrition, illness and cruelty. In the first thirty years of colonisation, huge numbers of Aboriginal people died from disease and displacement, further reinforcing the European 'scientific' belief that they were a dying race. Although the Proclamation stated that Aboriginal people had all the rights and privileges of British subjects before the law, including voting rights, this was not put into practice. British law did not take into account the practical situations arising through colonial conflict and loss of land (Gale 1972). In response to the visible 'plight of Aboriginal

peoples, missionaries and humanitarians advocated the establishment of missions, (Gale 1972; Human Rights and Equal Opportunities Commission (HROEC) 2005).

Christian missionaries had been involved in providing food and shelter since the beginning of South Australian settlement. Many free settlers were deeply religious and actively encouraged Aboriginal people to become educated in Western literacy and convert to Christianity while supplying their basic needs. The government supported this activity, believing that it would assist conformity and assimilation into western Christian society (Gale 1972). By 1856 Missions, rather than the government, became the main agency providing care, rations, shelter and education for Aboriginal people. In many instances, in order to receive assistance, Aboriginal people had to embrace Christianity and abandon their cultural heritage, social structures and languages (Gale 1972).

Some missions were developed by people who wished to keep Aboriginal people safe within a dangerously discriminating settler society. Dr Charles Duguid wrote of being so appalled by the overt discrimination, high rates of infectious diseases, sexual assault and violence that he found in the north of the state in the 1930s. He spoke with white men who had *taken* Aboriginal women, had children with them, and then removed them if they began to show signs of sexual diseases or if a white woman came to be his wife. One such man was questioned by Dr Duguid as to where the Aboriginal woman and resulting children he had seen on the last visit were. He replied '*Oh I dumped them and the lubra in the Ranges*' (Duguid 1972). Duguid returned to Adelaide and applied to the government to start a new mission at Ernabella (Pukatja). His vision was to enable Aboriginal people the freedom to live their lives as close to tradition as possible and to be safe from Western violence. He argued that medical and education staff should learn the local Pitjantjatjara language, and that adequate medical facilities to treat Western related illnesses should be provided. Ernabella mission opened in 1937 (Duguid 1972) and the community has continued to operate in one form or another until now. Some of the Aboriginal women attending services in Adelaide today come from Ernabella and speak of Dr Duguid and his legacy.

Segregation – separation and control of Aboriginal people

Regardless of intent, from the 1860s to 1950s Government policies led to Aboriginal peoples being segregated from mainstream society across Australia. Within South Australia, Aboriginal people were sent to missions, children's homes or fringe settlements outside of towns and homesteads, and their lives were highly regulated by colonial authorities. Many Aboriginal people were forcibly removed from their home country and sent to missions across the state (Brodie & Gale 2002; Mattingley & Hampton 1998). Forcing differing tribal and cultural groups to live alongside each other sometimes led to conflict and/or culturally unsafe situations. Aboriginal people were given very few rights or freedom of movement. They had to seek permission to enter or leave a mission, and all their movements, finances, homes, supplies and marriages controlled by the mission managers, police and government officials (Mattingley & Hampton 1998). A total of 25 missions were established across South Australia (Mattingley & Hampton 1998).

In 1913 the Adelaide 'Protector of the Aboriginals' described missions as providing a useful solution to 'Aboriginal problems'. He wrote

The Aborigines who used to infest the city and suburbs have all been removed and placed on Point McLeay, where they are kept and provided for under the Act. They are quite happy there and behave themselves well (Chief Protector of Aboriginals 1913).

He further advised the Supervisor at Point McLeay;

The Aborigines (both male and female) who were removed to Point McLeay on 31 January are not allowed to leave the Reserve without a permit from you...They are liable to six months imprisonment should they go away without a permit which must not be for more than a fortnight nor extend to any town or township (in Mattingley & Hampton 1998, p. 116).

This report clearly shows the lack of choice or rights that Aboriginal people were given, how tightly their movements and actions were monitored and controlled, and the role that missions played within this. Aboriginal people were no longer free to move across the land gathering food, medicines, or visit spiritual and healing places. They were also less able to control their own lives, safety and relationships.

The only way for Aboriginal people to (legally) leave missions was to receive permission or to gain an exemption stating that they were no longer Aboriginal (Aboriginal Women's Reference Group 2005). Auntie Veronica explains;

A lot of Aboriginal people lived in Adelaide when I was young. They were usually the Aboriginal people who had gained citizen ship rights, either Aboriginal women who had married white men or because they had applied for citizenship. They were classified as white people by the government and had more freedom (Brodie & Gale 2002).

If these options were not possible, Aboriginal women were at risk of being forced to remain in unsafe situations. Once again I refer to Auntie Veronica Brodie who discusses how Christian morals, Western values and mission rules forced her mother to return and stay in a violent relationship;

I had many silent thoughts about my Mothers' marital problems. I think at one stage my mother and father separated. Later it became apparent to me that my mother had fallen in love with another chap, Proctor Wilson, my dad's cousin. She left my dad and took myself and my brother and sister to live with him.

Years later I received a letter from Mrs Marjorie Angas, previously a welfare officer of the Aborigines Protection Board, telling me about this great love affair between my mother and Proctor Wilson. The letter said that mum was ordered back to Rauukan by the Protection Board and told to go back to her husband. You see they had a hold on her, because if she didn't go back, then they would have taken us children away.

There was always this constant threat over people with children. The happiness of the children didn't count. The Protection Board just laid this on us, and that was it. We had to jump when told, or else. That was their way of dealing with you (Brodie & Gale 2002, pp. 45-6).

Auntie Veronica goes on to say that her mother spent many years in a violent relationship, separated from the man she loved. To protect her daughter from the abuse, she sent her to Adelaide to live with her aunts. Often Aboriginal women, their partners and families experienced the trauma of having their children removed. This has become known as *the stolen generations* (Human Rights and Equal Opportunities Commission (HROEC) 2005).

The stolen generations – empty arms and vulnerable children

Young women were taken to live in children's homes, and then sent to township or station homes as servants. Often they were not paid in cash, and so could not gain financial independence (Hampton & Mattingley 1998; Mattingley & Hampton 1998). Postcolonial and feminist Aboriginal authors such as Aileen Moreton Robinson (2002) highlight the role that white women played in the oppression of Aboriginal women. Challenging (Western) feminist concepts of solidarity among women, she notes that many white women settlers were complicit in colonisation practices by their actions or inactions, such as being violent toward Aboriginal women, and beating or punishing them in domestic situations. These behaviours were justified by an underlying belief that Aboriginal women were lesser beings, primate and unfeeling (Moreton Robinson 2002).

The National Inquiry into the separation of Aboriginal and Torres Strait Islander Children from their families highlighted that between 1863 and 1970 approximately 1 in 10 or 100,000 Aboriginal children were removed from their families across Australia. For some families and communities, this meant that three successive generations of children were taken away (Allam 2001; Human Rights and Equal Opportunities Commission (HROEC) 2005). Huge levels of grief, loss, mistrust and self harm continue to this day in response to this appalling government practice (Human Rights and Equal Opportunities Commission (HROEC) 2005)

Two years after the National Inquiry, the *Bringing Them Home* report was released (Human Rights and Equal Opportunities Commission (HROEC) 2005). Over 700 personal stories were recorded along with wide consultations and public forums. One in five Aboriginal people reported having been sexually abused while in an institution, a quarter of children fostered or adopted were also sexually abused. One in six spoke of excessive physical punishment.

The justification for the removal of Aboriginal children by the government was that they would have improved opportunities, but the study found that being 'removed' did not lead to higher levels of education or employment. Rather people experienced increased incidences of suicide, alcohol and substance misuse, an inability to form relationships, increased mental health issues, shattered families and communities, and difficulty in parenting. The inquiry declared that the removal of Aboriginal children was primarily an act of genocide (Allam 2001; Human

Rights and Equal Opportunities Commission (HROEC) 2005). The inquiry into Aboriginal Deaths in Custody (Human Rights and Equal Opportunities Commission - HROEC 1991) found that 80% of those who had suicided had been in institutions at some time during their childhood, reinforcing the detrimental impact this policy had on Aboriginal Australians.

Similar findings of abuse, sexual assault and long term health and well-being effects have emerged in Canada from research into the ongoing effects of Residential Schooling where Canadian Aboriginal children were removed from their families and communities, prevented from speaking their own languages and learning about their heritage and cultures. This highlights the international effects of colonising actions (Battiste 2004; Varcoe & Dick 2008).

When the Royal Commission into Aboriginal Deaths in Custody (Human Rights and Equal Opportunities Commission - HROEC 1991) and the Bringing them Home Report (Human Rights and Equal Opportunities Commission (HROEC) 2005) outlining the personal and community consequences of incarceration and the removal of Aboriginal children were released in the late 1990s, they triggered mixed response in Australian society. Many Aboriginal people were relieved that their stories were finally heard and recorded. Many non-Aboriginal people found the reports shocking and the country was divided in its response – some wanted action, some refused to acknowledge the report, and others wondered if the claims of atrocities were really true. Official national political recognition of these colonising actions did not occur until 13th February 2008 when Prime Minister Kevin Rudd formally apologised to the Stolen Generations and their descendants in his first parliamentary sitting as incoming Prime Minister. The apology was passed by both houses of Parliament (Rudd 2008; Welch 2008). There is another historical issue however, that has not been officially recognised or apologised for at a national political level, and that involves denied employment opportunity and unpaid wages.

Denied employment opportunities

For those on missions, segregation and regulation severely limited their attempts to become independent or enterprising, and provide for their families. The bureaucracy, particularly the ‘Protector of the Aboriginals’ refused many requests. For example in 1916 Albert Karloan of Point McLeay applied for a loan of 150

pounds for a cinematograph unit, a petition supported by his local Mission superintendent. However the Chief Protector of the Aboriginals WG South replied that;

This is a ridiculous request and similar ones are becoming frequent. If one Native be assisted it brings heaps of other requests. We are doing everything possible to find employment for the Natives on the stations and I recommend that from this date no further assistance be given any Native for purchasing Boats, Nets, Guns etc until the end of the war.

Similarly, Walter Tripp of Victor Harbour was denied the opportunity to set himself up on a small property at Hindmarsh Valley with a wattlebark project, even though there was local support for the idea, and a ready market.

The “Protector” wrote;

“A thrifty man could make a living on it, but I do not think any Aboriginal would be able to do so. Walter Tripp is a decent hard working fellow but it is doubtful that he or any other Aboriginal would prove a success on land of their own”. (Moulden 1918)

Instead it was proposed that such businesses continue to be controlled by white men, with Aboriginal men earning a basic wage. Similarly Winifred Wanganeen of Point Pearce applied unsuccessfully for assistance in setting up a soft drinks stall to serve wheat lumpers at Balgowan (Mattingley & Hampton 1998). These repeated refusals condemned Aboriginal people to continually receiving only low income and whatever welfare assistance was available.

Assimilation policies – getting thrown in the deep end to sink or swim

During World War II many Aboriginal men and women assisted in the war effort at home or overseas. Following the war, the Federal Government moved from a policy of segregation to assimilation. Many ‘white’ migrants came to Australia and were encouraged to assimilate into mainstream society, and there were expectations that Aboriginal people would assimilate as well. Funding for missions, rations and government assistance was reduced and with a national trend toward urbanisation, many Aboriginal people found themselves moving into urban areas with few skills to survive urban capitalist society.

The Assimilation Policy of 1951 clearly stated that;

All Aborigines shall attain the same manner of living as other Australians, enjoying the same rights and privileges, accepting the same responsibilities, observing the same customs and being influenced by the same beliefs, hopes and loyalties (in Eckermann et al. 2006, p. 26).

While this policy had humanitarian intentions, it was based on beliefs that Aboriginal people would benefit from assimilation into Western society, and that such policy intentions could be implemented in society, organisations and governments that still held ideals of protection, segregation and inequality. Most Aboriginal people had little or no income after being severely underpaid workers for many years. Having few resources or previous experiences to prepare them for living in a suburban area, they often stayed with relatives who had been in the city longer leading to overcrowding and complaints from landlords and other residents. Newcomers were forced to move from one set of relatives to another or one form of temporary accommodation to another, leading to increased mobility and disruption (Gale 1972).

Relocation was very traumatic for many Aboriginal people, especially those who went from *complete segregation* to *assimilation*. One Aboriginal man shared his experiences of moving from a reserve to mainstream society, saying;

On the mission you're locked in, you're afraid to go off. ..

When you move off the mission, it takes a long time for people to change their ways. You've been locked off from all that information that all the others take for granted. You continually have to learn new steps; you've never got a stable position.

Children have to learn new things. You have to tell your kids to do things you've never done yourself. You're not of that system. You've learned one set. Then you have to learn another set. You've been brought up like cattle, ring the bell, means you have to go to bed – you've been protected in this little place and suddenly you've got to go out. You don't know how to ask people, how to talk to people. You've never even been taught the rules of conversation. You've been brought up not to talk out of turn. By law you can't talk to white

people, that's consorting (Lewis O'Brien in Mattingley & Hampton 1998, p. 145).

This account highlights the personal cost and 'on the ground effects' of government policies. Even with official assimilation policies, Aboriginal people living in suburban and township areas continued to be subject to high levels of discrimination, segregation and exclusion (Mattingley & Hampton 1998). Often Western concepts of health and hygiene were used to reinforce racial segregation. For example, in the 1950s Aboriginal people were still segregated into substandard parts of hospitals, banned from using swimming pools, barbers, and reusable cups in milk bars (Curthoys 2002).

A movement toward recognition, collaboration and inclusion

The 1950s and 60s were also a time of Aboriginal activism. In 1965 Charlie Perkins led 'freedom ride' bus tours in rural New South Wales to protest against racial discrimination. With a positive result in the 1967 referendum, the Commonwealth Government officially recognised Aboriginal people as equal Australian citizens and legislated to provide national Indigenous health, education, housing and employment programs. While many Aboriginal people took the opportunity to enter training, higher education, work places and advocate more strongly for improved conditions for Aboriginal people, the majority were unable to do so due to lack of available resources, access issues and personal and family situations. In 1972 Aboriginal people set up a tent embassy in Canberra to demonstrate for land rights.

One of the unfortunate negative impacts of equal wages in outlying areas was that many pastoralists replaced Aboriginal workers with white workers during a time of improved technology and a downturn in the meat industry. This situation led to many Aboriginal people having to leave meaningful employment *and* their Traditional lands and move to the nearest towns. In the 1970s and 1980s Aboriginal people sought to establish homelands on their Traditional lands, enduring legal, bureaucratic and welfare battles to do so (Mitchell 2007).

Integration, self determination and self management

From the mid 1960s onwards, government policy statements have discussed *integration, self-determination and self-management*. Integration refers to an

emphasis on positive relations between Aboriginal and the wider community, while recognising that Aboriginal people may have different needs and aspiration in some aspect of their lives. Self determination took these different needs and aspirations further, recognising that Aboriginal people should have the right to choose their own destiny. With self determination the government's role would theoretically be one of enabling and supporting, providing finance, technical skills and social and economic support. Self management has similar aims to self determination but stresses that Aboriginal groups must be held accountable for their decisions and management of finance (de Hoog & Sherwood 1979; Eckermann et al. 2006).

During the self determination and self management eras of the 70s, 80s and early 90s there was an upswing in the Aboriginal political movement nationally and internationally. Community controlled health services, housing and self help programs were established. Unfortunately, many of these were non-Aboriginal inspired and supervised endeavours and a large percentage of funds were spent on consultative fees and salaries for non-Aboriginal experts, supervisors and administrators who did not embed their practice in knowledge sharing or collaborative action. When programs failed there was a 'white backlash' and a general public outcry of a waste of tax payer's money (de Hoog & Sherwood 1979). This 'blame the victim' response placed Aboriginal people, rather than our shared history of colonisation and hegemonic practices, inequities and exclusion as the problem (Ryan 1976). Eckermann, Dowd, Chong, Nixon, Gray and Johnson reflect on this victim blaming tendency by saying;

If the 'problem' and the 'solution' are developed by outsiders and the program fails, then it becomes easy to blame the recipient of the 'humanitarian action program' (Eckermann et al. 2006, p. 29)

They identify the importance of understanding policy aims claims and outcomes, rather than casting blame.

During the 1990s, grassroots reconciliation groups began meeting and in the year 2000, thousands of Australian people marched together in a Reconciliation rally showing support for Aboriginal people. The Federal Prime Minister however stated that he would not accept a 'black arm band approach' to Australian history and refused to make a public apology (Eckermann et al. 2006).

In 2004, the Aboriginal and Torres Strait Islander Commission (ATSIC), the national voice of Aboriginal people was abolished by the Federal Coalition government due to allegations of misconduct by the Chair and Deputy Chair. Aboriginal communities across the country watched in disbelief as they lost their only autonomous, elected national Aboriginal voice. It was replaced by a Government elected National Indigenous Committee which itself disbanded in January 2008 (Eckermann et al. 2006). During the 2000s Aboriginal controlled education, employment and support programs became increasingly incorporated into mainstream services or were de-funded (Eckermann et al. 2006).

In 2007, the Little Children are Sacred Report or *Ampe Akeyernemane Meke Mekarle* was released as a result of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse (Northern Territory Board of Inquiry 2007). The 2007 pre-election government strategy involved declaring a *national emergency* and sending police and army personnel into communities to ‘stamp out child abuse’. Alongside this were strategies of alcohol restrictions, welfare reforms, enforced school attendance linked to income support, compulsory health checks for all Aboriginal children, acquisition of Aboriginal townships by the government through five year leases, reversing Traditional land permit systems, banning pornography, improving governance, increasing policing levels, ground clean up and repair of communities to make them safer, and improving housing and reforming community living conditions through introducing market based rental. Doctors, nurses and other professions were encouraged to volunteer their time and expertise to the cause (Brough, Mal 2007; Brough, M 2007a, 2007b; Department of Parliamentary Services 2007; Hinkson 2007; Senate Committee 2007).

This strategy was met a very mixed response by both Aboriginal and non-Aboriginal people, and was primarily maintained by the newly elected Federal Labor Government. Many view the strategy as a short term, high publicity response to sensitive and complex issues tied to colonisation history and practices (see for example Anderson, 2007; Atkinson 2007a, 2007b; Calma 2007; Dodson 2007; Hinkson 2007). Many others felt it was at last a move toward action. Aboriginal leaders and academics continue to debate the issues in press releases, articles and books, highlighting complexities and advocating for more balanced, planned and culturally safe and respectful strategies. At the time of writing, there are still mixed

feelings about the strategies, their underlying philosophies and their potential for benefit and harm.

In 2008 the Northern Territory Emergency Response (INTER) Review Board (2008, pp. 9-10) found that;

The single most valuable resource that the National Territory Emergency Response lacked from its inception is the positive, willing participation of the people it was intended to help. The most essential element in moving forward is for government to re-engage with Aboriginal people... based on genuine consultation, engagement and partnership.

The review board found that in many Aboriginal communities there was a deep belief that the measures introduced by the Australian Government were *a collective imposition based on race*.

The review discusses the need for new ways of moving forward that are based on trust and an active re-engagement with community by government. They found that the emergency response fractured an already tenuous relationship and led many Aboriginal people to feel as if they were alien and repugnant to the rest of the country. In the review, Aboriginal people repeatedly spoke of racial discrimination and humiliation, of hurt and anger at being *subjected to collective measures that never would be applied to other Australians* (p 8). Many Aboriginal people expressed an opinion that;

Aboriginal people and their culture have been seen as exclusively responsible for problems within their communities that have arisen from decades of cumulative neglect by governments in failing to provide the most basic standards of health, housing, education and ancillary services enjoyed by the wider Australian community (p 8).

Support for the emergency response measures diminished through the way it was imposed, particularly a failure to work collaboratively with local communities and with local health professionals. Despite this, some gains have been made such as police stations in communities, reduction of alcohol related violence, improved housing, education and employment opportunities. The Review Board recommended that intervention measures continue in a modified form that involves community development and partnerships between community and government,

governed by principles of informed consent and respectful participation. Health services that could best responded to these recommendations and principles would involve comprehensive primary health care as discussed in the next chapter.

Aboriginal women as advocates

Aboriginal women have had both similar and different experiences of colonisation as Aboriginal men. Both men and women have been subject to colonising effects as children, partners, parents and grandparents. There are however, some differences in their experiences linked to gender. Aboriginal women, like Aboriginal men, have played a very significant role in the relationships between Aboriginal and non-Aboriginal peoples across Australia. Sometimes they took the initiative, at other times the role was forced upon them (Atkinson 2002; Duguid 1972, p. 97). Aboriginal women became mothers of white men's children, had their children taken away, gained knowledge and insight into European ways by working within Western homes, supported lonely European women in remote areas, assisted in childbirths, and became staunch advocates for improved conditions for Aboriginal families and communities (Hampton & Mattingley 1998; Mattingley & Hampton 1998).

Over many years Aboriginal women have experienced complex judgements, discriminations and exclusion associated with being positioned as an Aboriginal, poor and female 'other' within Australia's white, patriarchal capitalist society (Moreton Robinson 2002). Despite this, they have repeatedly advocated for, and worked with others to obtain, improvements for their families and communities (as have Aboriginal men). In South Australia, Aboriginal Elder women have agitated for and initiated improvements in the health, legal, policing, housing, education, childcare and welfare systems, co-creating women's shelters, Aboriginal Outreach Health Services, youth programs and strong cultural ties (to name a few) (Mattingley & Hampton 1998).

Examples include the Council of Aboriginal Women of South Australia in the mid 1960s when they decided to 'do something' in response to the increased pressures of assimilation, urbanisation and poverty. In 1973 the men decided they wished to join them, and together they started legal aid, and then the Aboriginal Community Centre, and health service (Mattingley & Hampton 1998). At times Aboriginal

women have actively worked in collaboration with mainstream, community health and feminist organisations to conduct research, increase services and lobby for changes.

The impact of colonisation, discrimination and exclusion on health

Put simply, for most of the last two centuries, white Australia has been bad for Indigenous Australian's health (Mitchell 2007)

Despite possible gains, repeated colonisation, discriminating and exclusionary practices over the last two hundred years have had a very damaging effect on most Aboriginal women's health and well-being (Eckermann et al. 2006). As well as challenges to physical health, there have been many challenges to Aboriginal people's mental, emotional, spiritual, cultural, social and economic health (Atkinson 2002; Mowbray 2007). High levels of grief and loss, and frustration with continual and new colonising practices, discrimination and oppression, further impacts on their health and well-being. Fighting for improvements over many decades has been exhausting for Aboriginal peoples (Aboriginal Women's Reference Group 2005; Atkinson 2002; Community consultations 2005). Throughout most of Australia's colonial history, Western health provision for Aboriginal people has been second class, closely reflecting the colonial and discriminating attitudes of mainstream white society. Segregation was held firmly in place until the 1960s with many public hospitals maintaining segregated services for Aboriginal and non-Aboriginal people. Health care for Aboriginal people was often provided in a substandard tin annex separate to the main hospital building. Older Aboriginal women discuss birthing their babies on the side of road after being turned away by a local hospital. The justification for such actions was 'the hygiene risks' to white patients (Curthoys 2002; Mattingley & Hampton 1998; Mitchell 2007).

An increased awareness of the severity of health issues for Aboriginal peoples was triggered by a public campaign launched by Aboriginal organisations in the 1960s. Prior to this little attention was paid to Aboriginal health with many Aboriginal people living segregated lives from the rest of society in fringe areas and slums and

with poor access to adequate food, housing, income, employment and education (Eckermann et al. 2006). In the 1960s Aboriginal activists highlighted that while Australia was becoming more committed to international aid for refugees and war victims; Australia's own minority groups were experiencing some of the worse health outcomes in the world. Central Australian people had **the** highest infant mortality rates in the world, with one in five babies dying before the age of four. This was ten times the Australian national average. Even in urban areas infant mortality rates were at least twice as high for Aboriginal families (Moodie 1973). Overall, the gap between life expectancy for adult Aboriginal men and women was approximately twenty years below that of other Australians (Eckermann et al. 2006).

While Australia as a nation was becoming more committed to international aid for refugees and war victims, it had still not addressed the health issues of its own minority groups. Prior to 1968, each state was individually responsible for Aboriginal health care and commitment varied greatly between states. It was only after the 1967 national referendum that the Federal Government began to legislate for Aboriginal Australians and began funding national Aboriginal health programs (Anderson, I 2002). Since the 1970s, significant changes to health care for Aboriginal people occurred and are discussed in depth in the next chapter.

A comparison of Aboriginal people's experiences, with Aboriginal and health policies and interventions, highlights that the end results may be vastly different than the intention. In the following Table 2.1 I have brought together the health eras, dominant policies, activities and interventions, and how these have been experienced and perceived by Aboriginal people. Dominant health and government ideologies can be seen to impact on Aboriginal people's health and well being. Some of the information in the table relates to primary health care and public health is discussed in Chapter Three. This table is purposefully positioned here rather than in the next chapter to highlight the impact that discriminating and exclusionary practices associated with colonisation have had on the health and well being of Aboriginal people.

Table 2.1 Comparison of public health eras, policies, practices & Aboriginal health experiences (Kelly 2008)

| Health era | Dominant policies and activities | Mainstream health intervention models | Aboriginal health experiences & Aboriginal policy eras |
|---|--|---|--|
| 1. Indigenous - pre invasion & colonisation | | | |
| | | | Strong relationships between people, land, spirituality, family, community and personal well-being |
| 2. Post Invasion & colonisation 1788 – 1890s | | | European invasion & settlement 1788 – 1880s |
| Colonisation | Control of infectious diseases Improved sanitation | Quarantine Acts (particularly of Aboriginal people) Provision of clean water and sanitation for settlements | *Conflict and resistance *Sickness/loss of heart, land, leadership, traditions, language *Massacres, dispossession, small pox, STI's *Malnutrition, forced change of diet |
| 3. Nation Building Era 1890-1940s | | | Segregation & protection 1890s – 1950s |
| Public health promotion | *State & federal action to improve the health of the (white) nation. | *Formation of Commonwealth Department of Health | 1911 legislation saw Aboriginal people as a dying race (Darwinism) |
| Bubonic Plague (1900) | *Health linked to ideas of vitality, efficiency, purity, virtue | *Organised open air exercise programs, | *Chief Protector is legal guardian of all Aboriginal children –many of whom were removed from their families |
| World War I | *Poor management of waste products into waterways | *Medical inspection of school children *Hygiene advice to population *Increased understanding that social and economic factors effect | *Extensive disease and loss of life due to infectious diseases *Living on missions & government reserves *Poor housing, health and employment |

| | | | |
|---|---|---|---|
| <p>(1914-1918) World war II (1939 – 1945) Korean War (1950 – 53)</p> | <p>*Chinese accused of spreading disease and plague *Compulsory quarantine for infectious illnesses Many Australians killed and injured in the wars</p> | <p>health *1920s/30s maternal and infant health programs established</p> | <p>*Rations consisted of tea, flour, sugar and salt beef *Aboriginal people’s wages unpaid, taken, stolen, misplaced & redirected into Government funds by employers, protection officers, police officers and government officials. *1930s – strong Aboriginal activism *Aboriginal people served in all wars.</p> |
| <p>3. Post World War II – Affluence, medicine and infrastructure 1950s – early 1970s</p> | | | <p><i>Assimilation</i> 1950s – 1960s <i>Integration</i> 1967 - 1972</p> |
| <p>International aid for overseas sick & war veterans High immigration, low unemployment 1960s Lifestyle era Vietnam War involvement from 1962-73</p> | <p>*Economic affluence *Interventionist government *Commitment to improving quality of life *Considerable developments in clinical medicine *A belief that medicine would conquer disease. *Mass screenings *International growing interest in civil rights</p> | <p>*Considerable intervention in areas which have an impact on health, i.e. housing and education in 1950s. *Health services focused on sophisticated medical technology, drugs, surgery. *Public health staffed by ex-military medical officers *Expanding health budget focused on hospitals, little spending on public health *1950s – tuberculosis screening & polio immunisation *1950 – National Heart Foundation</p> | <p>*Many Aboriginal children continued to be removed from their families Stolen Generation *1967 Referendum – Aboriginal people now to be paid equal wages to non-Aboriginal people *1968 National co-ordination and funding of Aboriginal health programs *Often surviving in poor environmental and living conditions *Infant mortality greater than any Asian or African country *Growth of Black Power movement *Aboriginal people kept at margins of society and systems by mainstream</p> |
| <p>4. Lifestyle Era Late 1960s - mid 1980s</p> | | | <p><i>Self determination</i> 1972 – 1975 <i>Self management Stage 1</i> 1975 - 1988</p> |
| <p>1973 oil crisis, recession,</p> | <p>*Economic rationalism</p> | <p>*Lifestyle programs – addressing</p> | <p>*Strong push for self reliance, but subject to</p> |

| | | | |
|--|--|---|--|
| <p>increased unemployment</p> <p>1978 Alma Ata Declaration of Health for All</p> <p>Post Vietnam War social changes and challenges</p> | <ul style="list-style-type: none"> *Chronic disease focus & effects of affluence *Rediscovery of prevention *A need to control escalating health costs *Focus on individual behaviours – behaviour modification & lifestyle programs *Increased recognition of multicultural society *Epidemiology *Increased environmental and human rights movement | <p>diabetes, cancers, smoking etc</p> <ul style="list-style-type: none"> *Population surveys of risk factors *Growing interest and development in public health, community health, women’s health, Aboriginal health *1970 Family Planning SA *1973 community & women’s health centres opened. *1975 Medibank (Australia’s first universal health insurance scheme) *1983 Medicare introduced | <p>“we’ll help you to do what we want you to do”</p> <ul style="list-style-type: none"> *1970 National Aboriginal and Islander Health Organisation formed *1971 First Aboriginal controlled health service in Redfern, Sydney *Tent embassy in Canberra |
| <p>5 New Public Health Era Mid 1980s – 1990s</p> | | | <p><i>Self management Stage 2 1988 - 1996</i></p> |
| <p>Economic Rationalism</p> <p>1986 Ottawa Charter</p> | <ul style="list-style-type: none"> *Costs of medical treatment questioned *WHO policies gaining influence *Focus on collective measures *Emphasis on poverty and social justice in public health policies *Economic recession and cutbacks in state expenditure | <ul style="list-style-type: none"> *Development of healthy public policy i.e. tobacco & alcohol legislation, *Policy support for community involvement in health promotion *Settings approach to health promotion - i.e. Healthy Cities *1984 Australian Community Health Association formed *1985 National HIV/AIDS strategy *1987 SA Health Promotion Foundation established | <ul style="list-style-type: none"> *1989 National Aboriginal Health Strategy established *ATSIC introduced *Increased emphasis on housing, health, employment, education in response to more vocal Aboriginal concerns *Wik Decision *10 point plan that limits Native Title rights *1991 the Royal Commission into Aboriginal Deaths in Custody Report & recommendations *1992 the Council for Aboriginal Reconciliation |

| | | | |
|--|---|---|--|
| | | <ul style="list-style-type: none"> *1989 National Women’s Health Program established *1991 National Breast screen & cervical screening programs | <ul style="list-style-type: none"> *1997 Bringing them home report – Stolen Generation *1998 National Sorry Day initiated |
| 6. Global New Public Health Mid 1990s to early twenty first century | | | <i>Shared responsibility and mutual obligation [2000s]</i> |
| Jakarta Declaration | <ul style="list-style-type: none"> Recognition of effects of global economy Global communication Recognition of impact of chronic conditions | <ul style="list-style-type: none"> *Shared Responsibility & Mutual Obligations – 2004 Federal direction | <ul style="list-style-type: none"> *Mainstreaming of services, including Aboriginal Health Services *2000 Health is life report on the Inquiry into Indigenous Health *2004 National Strategic Framework for Aboriginal and Torres Strait Islander health *ATSIC abolished in 2004 by government who argue it is inefficient and corrupt *“Child Abuse Emergency” & Government sends army and police into Aboriginal communities in Northern Territory * 2008 First national government apology to Stolen Generation |

From (Baum 2008; Eckermann et al. 2006; Mattingley & Hampton 1998)

As this table indicates, current Aboriginal health status has been shaped by policies and practices over the last two hundred years.

Current health statistics – the impact continues

In this first decade of the 21st century, Australia has still failed to ensure equitable improvements in the overall health and longevity of Indigenous peoples. While generally Australians are one of the healthiest populations of any developed country, with a world-class health system, statistics show minor improvements in Aboriginal health outcomes over the past ten years. Many Aboriginal people continue to experience the effects of acute and chronic illnesses, illnesses and serious disabilities, mental health issues, low birth weight babies, high rates of suicide and injury, and unresolved loss and grief. Life expectancy at birth for Indigenous people remains 17 – 20 years less than for non Indigenous Australians (Aboriginal Health Council of South Australia & South Australian Health Commission 1994, p. 9; Health Infonet 2007; Oxfam Australia 2007).

Infant mortality rates are three times the rate of non-Indigenous Australians and more than 50% higher than for Indigenous children in USA and New Zealand (Oxfam Australia 2007); Australian Indigenous children are five times more likely to die before the age of five years. Chronic conditions including heart disease, stroke, diabetes and renal failure represent a serious and escalating health burden for adults. They occur more commonly, and at a younger age in Indigenous compared to mainstream populations in Australia. Major contributing factors are persistent social and economic disadvantage coupled with poor access to health care and good nutrition (Oxfam Australia 2007, p. 5).

When compared to international trends, there is some thing startlingly wrong about the Australian situation. Other countries with a similar colonisation history that displaced Indigenous cultures such as Canada, New Zealand and the United States have seen reducing morbidity and mortality rates of Indigenous people becoming much closer to that of non-Indigenous. A comparison of life expectancy of non-Indigenous and Indigenous people in Australia, New Zealand, Canada and USA is presented in a table below.

Table 2.2 Comparison of life expectancy of Indigenous and non-Indigenous peoples

| | Life expectancy Indigenous people | Life expectancy of non-Indigenous population | % of Indigenous populations compared to non Indigenous population |
|---|-----------------------------------|--|---|
| Australia | Women 63 years Men 56 years | Women 82 years Men 76 years | 2.4% |
| Australia - 19 years difference in life expectancy | | | |
| New Zealand | Women 73 years Men 69 years | Women 81 years Men 76 years | 15.0% |
| New Zealand - 7.5 years difference in life expectancy | | | |
| Canada | Women 77 years Men 69 years | Women 82 years Men 76 years | 4.4% |
| Canada 7 - years difference in life expectancy | | | |
| USA | Women 74 years Men 67 years | Women 79 years Men 74 years | 1.2% |
| USA - 7 years difference in life expectancy | | | |

(Oxfam Australia 2007)

Many Aboriginal people express frustration at repeated statistics showing ‘how sick they are’ (Aboriginal Women's Reference Group 2005). The chart above has been included to provide a realistic overview of the current situation, a statistical benchmark that Australian health providers, policy makers and researchers can measure against and improve on, *in conjunction with* Aboriginal women and communities. These statistics are viewed as a reflection of a complex set of circumstances including colonisation, discrimination and exclusionary policies and practices, rather than individual life choices and behaviours.

Summary

In this chapter I have described the historical beliefs and cultural differences that underpinned and influenced racial and colonising practices in Australia over the last two hundred years. The abuse of power that Aboriginal people experienced, and white Australians benefited from has made the sharing of knowledge, collaboration and true understanding of each other impossible in most instances. In exploring this literature and history I have mapped different

factors that came together to make colonisation, inequity, discrimination and exclusion possible. The connection between these factors and the resulting experiences of poorer health and well being of Aboriginal women and their families is then made. I argue that colonising beliefs and practices have also impacted on health care policies and practices. While Government interventions may intend to resolve issues, they fail to account for the impact of colonisation and historical impacts, and therefore perpetuate the issues. These past and ongoing dynamics reinforce the need for knowledge sharing, working together and collaboratively addressing issues in health care. Figure 2.1 below provides a visual overview of how the factors discussed in this chapter relate to the central themes.

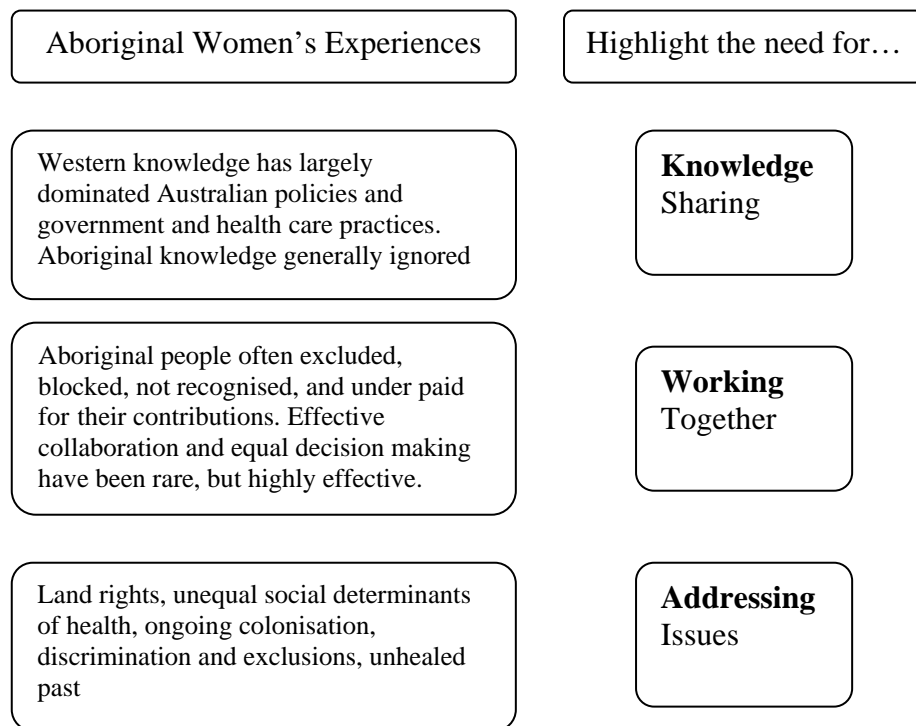


Figure 2.1 Aboriginal women's experiences highlighting the need for knowledge sharing, working together and addressing issues

This leads to questions of how Australian health policies, systems and professionals have responded to Aboriginal health and social inequities in Australia. In the next chapter I discuss the development of primary health care, Aboriginal health and women's health in community health settings in Australia

and South Australia over the last forty years, with a particular emphasis on the opportunities for knowledge sharing, working together collaboratively and addressing health care access and colonisation issues that each approach supported, or not.

Chapter 3 Primary Health Care for Aboriginal Women

In the previous Chapter Two, I have focused on the context of Aboriginal women's lives and the negative impact that colonising policies and practices have had, and continue to have on their health and well being. These experiences directly impact on Aboriginal women's experiences and decisions whether to access health care or not. In order to counter these negative effects, improved collaboration is needed. In this chapter, I focus on Aboriginal women's health care provision in community health settings. In particular, I discuss the specific philosophies, policies, programs and practices that have developed over the last forty years, and their varying levels of commitment to collaboration and engagement with Aboriginal women. I also discuss whether they address issues of social determinants of health and similar colonisation implications.

The three main components of Aboriginal women's primary health care in South Australia have been *primary health care*, *Aboriginal health* and *women's health*. Significantly, local, state, federal and international policy changes have led to a diverse, and at times confusing, range of health programs, experiences and expectations for both health professionals and Aboriginal community women clients. At times grass roots and ground up collaboration between community members, health professionals, policy makers and managers have been supported, leading to closer working relationships. At other times it has not. During the community consultations, Aboriginal women indicated that differing levels of collaboration determine whether health services are viewed as a *passing parade* or something that Aboriginal women can trust and engage with. The discussion in this chapter enables the experiences of Aboriginal women and Aboriginal and non-Aboriginal health professionals in the Collaboration Areas to be considered within a wider health policy, program and practice context.

Differing concepts of health and health care

Before focusing on health care approaches, I begin by discussing the very different concepts of health and health care that have existed between Aboriginal and non-Aboriginal people, and Indigenous and Western based health approaches. These differences impact on people's expectations of health care provision. In 1989 Aboriginal people from urban, rural and remote areas collectively defined what *health* meant for them in the National Aboriginal Health Strategy (1989, p. x) as;

Not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life – death - life.

This definition continues to guide contemporary Aboriginal health services today. Similarly, a group of Aboriginal and non-Aboriginal health educators who provide collaborative cross cultural training programs for non-Aboriginal health workers to work in remote areas have identified the importance of expanding understandings of health in post-colonial Australia to include;

Family, community, land, ties with the past and a vision of the future, hope and stability, dignity and freedom from anxiety, the right to make choices, economic security and absence of abuse (Eckermann et al. 2006, p. 149).

They identified that health cannot be dissociated from self-determination, land rights, cultural vitality, inclusion and equity (Eckermann et al. 2006). This viewpoint was reinforced during community consultations for this research when urban Aboriginal women identified that even when they have similar education and economic status to non-Aboriginal women, they find themselves being treated in discriminating and exclusionary ways. Their experience is that interacting with Western health and related services can be a mentally, emotionally and spiritually unhealthy activity for them (Community consultations 2005).

While many non-Aboriginal people also hold concepts of health as being holistic mental, emotional, physical, spiritual well-being, the Western health

system tends to focus on illness and health as the absence of disease. A biomedical understanding of health and ill health, focusing on the treatment of body parts with physical or chemical cures, became popular in the Renaissance Period and remains dominant in Western health systems today. The Cartesian view that the body and mind are separate and unrelated led to a belief that people's mental and emotional health was unrelated to physical illness (Capra 1985). Contemporary western concepts of health and well-being include a modified understanding of biomedicine that *focuses on* physical health and illness, *with consideration of* social and psychological factors that may have an impact. This provides some increased, but not focused, understanding of the ongoing impact of individual and collective colonisation experiences on the health and well being of Aboriginal women and their families (Atkinson 2002).

From an Indigenous perspective, biomedicine can be seen to be entrenched within a specific socio-political framework that privileges Western male biomedical knowledge over other forms of knowledge such as spiritual, cultural, feminine, personal and intuitive knowledge. This dominant view of ill-health as being physical and treatable has led to a situation where 'being healthy' has become an important aspect of being a 'good citizen', and ill health is synonymous with being an economic and societal burden. Those experiencing ill health for a range of environmental and socioeconomic factors, a position that many Aboriginal women find themselves in, are then blamed for being in that position (Baum 2008). If unchallenged, these beliefs associated with blame can negatively impact on the way health care is provided. When coupled with discriminating and colonising practices, health care becomes even more unfriendly and exclusionary.

Primary health care

As discussed in the Chapter One, Aboriginal health documents such as the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 (2004) advocate for partnership approaches and comprehensive primary health care. The Close the Gap Campaign (Oxfam Australia 2007) and Human Rights and Equal Opportunities Commission (Calma 2005) recognise the impact of poorer access to the social determinants of health on the health

and well being of Aboriginal people. In this section I discuss different interpretations of primary health care (selective primary care and comprehensive primary health care), the underlying principles, and implications that these have on health provision for Aboriginal women.

Historically, primary health care began in South Australia in the 1970s. Multidisciplinary primary health care services such child, mental and dental health, family planning, health education, immunisation, social work, domiciliary care and rehabilitation were developed with the support of the National Community Health Program (Baum 2008). Both (mainstream) community health services and Aboriginal specific health services adopted a primary health care approach to enable them to more effectively address wider social and financial issues. These activities predated the World Health Organisation Alma Ata Declaration, the first international focus on primary health care (Baum 2008).

The Alma Ata Declaration – a concept of health for all

In 1978, delegates from 134 countries (including Australian Aboriginal delegates) attended the World Health Organisation and United National Children's Fund (UNICEF) conference in Alma Alta and discussed ways of securing the highest level of health for the greatest number of people. Public health advocates, Indigenous peoples and governments spoke of increased health inequities and argued that the existing biomedical models were limited in their ability to address them (Baum 2008). Biomedical centred care, associated with increasing costs and limited impact, was proving unable to address the broader social, political and environmental issues that impacted on health and well-being (Johnson 2004; McMurray 1999; World Health Organisation 1978). This was particularly so for Indigenous peoples who often were positioned in the lowest socioeconomic situations. The Alma Ata Declaration promoted a new form of Public health with primary health care at its core. This was described as;

Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation

and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It is the first level of contact with individuals, the family and community with the national health systems bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing care process (World Health Organisation 1978, p. 6)

This vision of Health for All focused on a *more comprehensive* view of health with community participation and self-reliance within a health promotion and disease prevention framework. Technology was seen as only one aspect of a much wider response (Baum 2008; Johnson 2004). Concepts of social justice, equity and access, community development, empowerment and inter-sectorial collaboration underpinned this new approach. Specific attention was given to high risk, poor and vulnerable groups, including Indigenous peoples. The *new* public health encouraged people at grass roots levels to have a greater say in their health care, rather than passively receiving top down services (McMurray 1999), similar to the knowledge sharing and collaborative aspects of the 1970s Aboriginal health, women's health and community movement in Australia. The grass roots, bottom up, inside out approach was quite different to the previous top down health policy approaches. Experts could now be seen to be *on tap* rather than *on top* (Baum 2008). Opportunities for collaboration and de-colonisation strategies would increase with this approach.

Internationally, there were a range of responses to the new Primary health care model. According to Baum (2008), many *developing* countries adopted the comprehensive primary health care approach that considered the whole person in the context of their lives and living conditions, and promoted improvement in overall health and well-being of individual and communities. Non-medical interventions such as adequate food, housing, employment, education and community development were included. Community people were considered experts in their own lives and were encouraged to participate in designing health care that could best suit their needs. Most *developed* countries however, opted for a narrower selective approach to primary health care that maintained a clinical and biomedical focus on specific body parts and physical diseases,

with external specialists and experts continuing to hold and control both knowledge and power. These significant differences between selective and primary health care are important to consider in the context of Aboriginal women's health care, and are expanded in the table 3.1 below.

Table 3.1 Comparison of selective and comprehensive primary health care

| Primary Health Care | | |
|-----------------------------------|---|--|
| Characteristics | Selective | Comprehensive |
| Main aim | Reduction/elimination of specific diseases (<i>selective primary care</i>) | Improvement in overall health and well-being of community and individuals (<i>comprehensive primary health care</i>) |
| Assumptions about health | Health is the absence of disease | Health is a state of complete physical, mental and social well-being |
| Strategies/priorities | Focus on eradication, treatment and prevention of disease Medical care is most crucial | Comprehensive strategy, curative, rehabilitative, preventative and health promotion Non-medical interventions such as housing, education, food, environment are important |
| Planning and strategy development | External, often 'global' programs with little tailoring to local circumstances Professionals as experts on top | Local focus, reflecting community priorities who are experts on their own needs Professionals on tap not on top |
| Participation | Limited engagement, dependent on outside experts, tends to be sporadic. Focus on community compliance to medical solutions | Engaged participation that starts with community strengths and community assessment of health issues Ongoing, aims for community control |
| Engagement with politics | Professional and claims to be apolitical | Acknowledge that health care is inevitably political and engages with |

| | | | |
|-------------------------------------|--|--|--|
| | | local structures | political structures |
| Forms of evidence | Assessment of disease prevention strategy based on traditional epidemiological methods Usually conducted out of the situation and then used to explain what was happening within. | Complex research including epidemiology and qualitative methodology | and varied methods and participatory methodology |
| Knowledge sharing and collaboration | Professional knowledge valued over client knowledge or needs Compliance rather than collaboration | Both professional and client knowledge valued Two way knowledge sharing encouraged Collaborative action and community development underpins health care approaches | |

(Baum 2007, 2008, p. 34; Talbot & Verrinder 2005)

As this table shows, the two different forms of primary health care had significantly different approaches to knowledge sharing and collaboration.

In Australia, both comprehensive *and* selective approaches to primary health care developed in parallel during the 1980s as the country sought to develop a more efficient and equitable health system. A number of public health policy initiatives addressed structural issues and social determinants of health, while others addressed individual behavioural measures (Hancock 1999). For example the newly established Better Health Commission identified cardiovascular disease, nutrition and injury as three priority areas and the Health For All Australians report emphasised significant health inequalities that existed for certain groups in Australia including Aboriginal people (Better Health Commission 1986a, 1986b; Health Targets and Implementation Committee 1988).

There were both positives and challenges for this combined approach. On the one hand it assisted Australia to effectively address emerging issues that were impacting on health and well-being, such as HIV/AIDS (Baum 2008). On the other, the fluctuating and different approaches made it difficult for health

professionals and Aboriginal community women to know what levels of knowledge sharing and collaboration were likely in each health program and policy.

South Australian response to health for all

Many comprehensive primary health care initiatives expanded in South Australia in the late 1980s. Adelaide hosted the second International Health Promotion Conference with emphasis on healthy public policy, community participation and collaboration between all sectors of government. The South Australian Government launched a Social Health Strategy in 1988 (South Australian Health Commission 1988), and a Primary Health Policy in 1989 (South Australian Health Commission 1989). Healthy Cities, drug and alcohol, nutrition, child and adolescent health and mental health services were also developed.

However, difficulties in promoting and sustaining public health and health promotion activities at a political and economic level were experienced. Following the collapse of the State Bank in 1992 and the change from a Labor to Liberal State Government, long term strategies addressing poverty, education, housing, nutrition and income maintenance became increasingly difficult to defend politically at local and state levels (Baum 2008). Health minister John Cornwell reflected on the attempts to implement the new public health approach and comprehensive primary health care by saying:

The magic bullet approach... is much simpler than a necessarily complex approach based on the more accurate notion that health is the consequence of many and varied public policies interacting with the individual... At a political level the public policy approach lacks support because it produces results in the long term and is less visible than the short-term crisis intervention of heroic medicine. Coronary bypass surgery and level three intensive care for very low birthweight babies are newsworthy. Addressing questions of poverty, education, housing, nutrition and income maintenance to overcome the problem of very low birthweight babies is not possible in a 60 second television news segment. Nor will it boost ratings or sell newspapers. It is a longer term and less

dramatic intervention. It also implies on equity of important health-producing goods and services which we have not yet achieved [Cornwell quoted in (Raftery 1995, p. 35)]

This highlights the practicalities and realities of trying to implement primary health care models into capitalist societies and existing health systems where many people value individualistic care and biomedicine over broader population health and prevention strategies.

The Ottawa Charter –combining selective and comprehensive PHC

Similar issues were being grappled with at an international level, and drove the development of the next World Health Organisation health policy document. The Ottawa Charter for Health Promotion (World Health Organisation 1986) reflected a revised vision of health promotion and public health that incorporated both selective and comprehensive approaches to primary health care (Talbot & Verrinder 2005). Behavioural and lifestyle approaches were described as personal skills for (individual) health that existed within wider prerequisites such as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity (Baum 2008; World Health Organisation 1986). The Ottawa Charter encouraged the health sector to work beyond the biomedical model dependent on technical knowledge, toward practical and emancipatory knowledge.

Australian health care in the 1990s however, responded more to post-liberal and economic rationalist trend than to the vision of the Ottawa Charter. Health care policies moved away from multidisciplinary population based primary health care (embedded in knowledge sharing and collaboration) toward individualistic care, privatisation, user-pays systems and personal responsibility. Considerable funds were spent on reforming the General Practice (GP) sector and providing financial incentives to assist doctors to become more involved in primary health care activities and health promotion (Baum 2008). Within South Australia, community health services experienced funding cutbacks and were encouraged to focus on selective primary health care services focusing on chronic disease care and prevention rather than advocacy and community development activities. Whereas there were 13

separately incorporated women's and community health centres in the metropolitan area in 1993, a range of mergers and closures reduced this to four by 1996. In 1995 the SA Health Commission was realigned to a Funder, Owner, Purchaser, Provider structure that put a strong emphasis on outputs and efficiency for all health providers. Community health centres experienced budget cuts and a new reporting, organisational and funding arrangement that separated them from the tertiary sector (Laris 2002).

From 2000 to 2007 Australian national health care policies continued to focus on privatisation over publicly provided comprehensive primary health care (Wakerman 2007). In 2004-05 only 5% of the health budget was spent on community health services and 1.7 % on 'public health'. In comparison hospitals received 35.3%, medical services 17.8 % and medications 13.2% (Australian Institute of Health and Welfare 2006). The emphasis on biomedical dominated selective primary health care (now described as the first level of medical care) over comprehensive primary health care continued (Baum 2008).

Meanwhile, the internationally WHO movement (2005) advocated for increased recognition of the impact of social determinants of health on health and well being. The Commission on the Social Determinants of Health recommended interventions and policies to improve health and narrow health inequities through action on social determinants and addressing inequities.

South Australia Primary Health Care

In South Australia in 2003/4, the State Labor government initiated health system reform and a twenty year strategic plan based on Alma Ata primary health care principles and social determinants of health (Government of South Australia 2003c; World Health Organisation 1978; World Health Organisation). Citing challenges of a non sustainable health system, population changes, social determinants of health, changing burdens of disease, distribution of services, fragmentation and duplication and health inequities, the state government committed to making a better system of health delivery based on comprehensive primary health care (Government of South Australia 2003).

The existing health system was to be maintained while reforms were developed and implemented. Health practitioners and consumers were to have increased involvement in health planning and policy decisions. An emphasis on improving health services for the most vulnerable populations, including Aboriginal people, children, young people, the frail aged and those with a mental illness was highlighted (Government of South Australia 2003). Health services across Adelaide were rearranged into two major regions with community based primary health care services and tertiary services brought together under a single administration and management (Government of South Australia 2003b). The combination of national selective health care policies with state health reform and increased focus on comprehensive primary health care created complex policy, program and financial dynamics. Some Aboriginal and non-Aboriginal community health professional positions are jointly state/national funded and health professionals discussed their confusion in trying to meet the directives of both national (selective), and state (collaborative) health policies (Discussion with Aboriginal and community health managers, Gilles Plains, February 7, 2005). At the time of writing (November 2008), there has been little action by the state government to seriously implement comprehensive primary health care.

Aboriginal health

Prior to the 1970s, public health was delivered mainly in hospitals in line with the biomedical model with an emphasis on infectious diseases, medical therapies and surgical advancements (Baum 2008; McMurray 1999). As discussed in the last chapter, many Aboriginal peoples experienced sub standard care within hospitals, with health services and health professionals continuing the colonising practices, exclusion and discrimination that Aboriginal people experienced in the wider community. There were of course exceptions to this, but many Aboriginal women clearly remember times when they were refused entry to hospitals or were housed in annexes rather than the main building (Community consultations 2005; Eckermann et al. 2006; McMurray 1999). These experiences continue to impact on their health seeking decisions today.

The first National Aboriginal and Islander Health Organisation was formed in 1970, and the first Aboriginal controlled health service opened in Redfern, Sydney, in 1971 with the aim of improving access to health services for the local Aboriginal community in a culturally appropriate environment (Hunter & (NACCO) 2001). These developed well before the Alma Ata Declaration of 1978 and highlight that Aboriginal health services and policies have been advocating for effective primary health care to address health issues for many years. Aboriginal Health Services were developed across the country as Aboriginal values and practices were incorporated into community initiatives (Anderson & Brady 1999, p. 191). Aboriginal Health Services often began as grass roots movements with Aboriginal and non-Aboriginal staff members volunteering their services until funding could be obtained (Anderson, Ian & Brady 1999). Health service staff members embraced the principles of self-determination and accountability to the community. Two-way knowledge sharing and skills transfer between (usually) non-Aboriginal professionals and Aboriginal health workers was embedded into organisational services and collaborative health care practice (Anderson, Ian & Brady 1999).

The first South Australian metropolitan Aboriginal controlled health service Nunkuwarri Yunti was opened in Adelaide in 1971. Health programs were established with the aid of donations, a small amount of government funding and the 'services of an empathetic and dedicated doctor' and Aboriginal woman activist Mrs Gladys Elphick (Nunkuwarri Yunti 2008). Once again, the development of this service was driven by community based decision making, rather than top down policy decision making.

The first **National Aboriginal Health Strategy** (National Aboriginal Health Strategy Working Party 1989) was developed in 1989 following a comprehensive and inclusive national consultation process. It promoted a rights based framework to be used by health services, service providers and policy makers and planners (National Aboriginal Health Strategy Working Party 1989). The strategy clearly stated an emphasis toward comprehensive primary health care principles (and knowledge sharing and collaboration) by stating that;

Health to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines of the absence of disease and incapacity (National Aboriginal Torres Strait Islander Health Council 2004)

The Strategy went on to emphasise the importance of housing, health, employment and education. As a result of this strategy and increased funding, the number of Aboriginal controlled and Aboriginal focused health services increased during the 1980s and 1990s, particularly in rural and remote areas. However, issues related to resource limitations, staff availability and skills mix impacted on the effectiveness of health care practice (Baum 2008).

The 1990s were a time of highs and lows for Aboriginal people in relation to Aboriginal and health policies. Many significant decisions and documents were released and impacted on Aboriginal people's health, well-being and healing journeys. The Wik decision regarding land rights was passed, giving hope of increased land ownership, but then the 10 Point Plan was passed that limited Native Title rights and negated many of the potential gains (Eckermann et al. 2006; Fricke 2001). In 1991 the Royal Commission into Aboriginal Deaths in Custody Report was released, with significant recommendations for change within health, education, welfare and legal services. In 1992 the Council for Aboriginal Reconciliation began, and many health professionals and community peoples attended study circles and activities in the interests of improved understanding and relationships.

In 1997, the Bringing them home report was released (Human Rights and Equal Opportunities Commission (HROEC) 2005) describing the experiences of Aboriginal people who were part of the Stolen Generation, separated from their families as children as part of race based government policies. For many, this was the first time their experiences were publicly told and acknowledged, an important step in knowledge sharing and healing needed to counter colonising actions. In 1998 (a year later), the National Sorry Day was initiated to acknowledge the wrong that had been done to Indigenous families so that the healing could begin (National Sorry Day Committee 2008). Collectively these

reports and events raised the profile of Aboriginal health and well-being and encouraged primary health care and other services to review the ways that they worked with Aboriginal people. Overshadowing these actions was the Prime Minister's refusal to apologise for past and present colonisation practices. This became a topical point, particularly as the United Nation declared the International Decade of the World's Indigenous People from 1995 – 2004 (United Nations 1994).

A national move toward shared responsibility and mutual obligation

Four significant national programs and frameworks and documents have guided Aboriginal health policy and health care throughout the 2000s. The first was the **Aboriginal Primary Health Care Access Program** (APHCAP) was announced in the 1999-2000 Commonwealth Budget as a program of health system reform using a partnership approach to improve access to, and provision of, primary health care services for Aboriginal and Torres Strait Islander people (Nunkuwarrin Yunti 2008).

The **National Strategic Framework for Aboriginal and Torres Strait Islander Health**, prepared by the National Aboriginal and Torres Strait Islander Health Council (2004), was released in 2004. This document critiques past strategies involving independent approaches by individual government portfolios, operating without the support and partnership of Aboriginal and Torres Strait communities as being largely unsuccessful and having little impact overall. It describes the National Aboriginal Health Strategy released in 1989 as a landmark document built on extensive community consultation, that had never been fully implemented (National Aboriginal Health Strategy Working Party 1989).

The Framework advocated for an approach of shared responsibility, with partnerships between Aboriginal and Torres Strait Islander organisations, individuals and communities, and government agencies across all levels and sections of government (National Aboriginal Torres Strait Islander Health Council 2004). The National Strategic Framework was based on a commitment to nine principles of; cultural respect, holistic approach, health sector responsibility, community control of primary health care services, working

together, localised decision making, promoting good health, building the capacity of health services and communities, and accountability. Once again, adequately resourced and funded comprehensive primary health care, embedded in concepts of respectful knowledge sharing and collaboration, was advocated as the “crucial mechanism” for improving Aboriginal and Torres Strait Islander health (National Aboriginal Torres Strait Islander Health Council 2004).

Also released in 2004 was the **Cultural Respect Framework for Aboriginal and Torres Strait Islander Health** (Australian Health Minister's Advisory Council 2004). This framework was developed to support and encourage health services to consider how they could operate in culturally inclusive and respectful ways. Cultural respect was defined as the ‘recognition, protection and continued advancement of the inherent rights, culture and traditions of Aboriginal and Torres Strait Islander people’ (Australian Health Minister's Advisory Council 2004, p. 7). The framework encouraged multilevel action from government planning to face to face service delivery.

Based on human rights principles, comprehensive primary health care and postcolonial concepts, this document defines health holistically, and discusses the effects of ongoing colonisation, discrimination and social factors on Indigenous health in Australia. It states;

The relatively poor health outcomes for Aboriginal and Torres Strait Islander peoples are the result of a complex set of interacting factors, one of the most important of which is colonisation. Social factors such as income, education and employment combine with health risk factors such as poor living environments, poor nutrition, excessive alcohol consumption, smoking and lack of physical activity. Other factors include loss of control, lack of social capital and the pervasiveness of loss and grief (Australian Health Minister's Advisory Council 2004, p. 5).

Within the document, the health of Aboriginal people in Australia is compared to that of Indigenous people in Canada, the United States and New Zealand, highlighting ongoing inequities and marginalisation in Australia. The Australian health system is critiqued as being unable to meet Aboriginal and Torres Strait Islander needs through being culturally inappropriate or

inadequately resourced. The need for mainstream services to be more responsive with improved performance and accountability, and staff that are 'culturally equipped to provide services to Aboriginal and Torres Strait Islander peoples is highlighted. For a country with no agreed cultural models of practice this is a significant document. However, at the time of writing (November 2008), the Framework has been discussed at higher organisational management levels (for example between Executive Officers and managers of Adelaide health services) but is still mostly unknown and unheard of by health professionals in Adelaide (Discussion with health professionals at Gilles Plains Community Campus, October 30, 2008). This highlights policy to practice gaps that impede the implementation strategies that could support respectful collaboration.

Close the Gap

The fourth major influence on Aboriginal health care has been the '**Close the Gap**' Campaign launched by Oxfam Australia (2008) and the Aboriginal and Torres Strait Islander Social Justice Commissioner, Tom Calma (2005). In 2005, Calma called for Australian Governments to commit to achieving Aboriginal and Torres Strait Islanders health and life expectation equality within 25 years, over one generation. The Close the Gap campaign, supported by Calma (2005), ANTaR¹⁰ and Oxfam¹¹ lobbied all levels of government to increase budget measures and support programs that *work with* Aboriginal communities. The campaign highlighted that there is a common public misconception that Aboriginal people's health care has been well resourced and financed, when in fact, the Federal Government spends approximately 70c per capita on Aboriginal and Torres Strait Islander people for every \$1 spent on the rest of the population. Oxfam Australia identifies that '*spending less on people with worse health is not good national policy*' (Oxfam Australia 2007, p. 8). This independent campaign sought to lobby governments, key decision makers and the Australian public.

¹⁰ ANRaR - Australians for Native Title and Reconciliation is an independent, national network of mainly non-Indigenous organisations and individuals working in support of justice for Aboriginal and Torres Strait Islander peoples in Australia.

¹¹ Oxfam Australia is an independent, not-for-profit, secular, community –based aid and development organisation whose vision is for a fair world in which people control their own lives, their basic rights are achieved and the environment is sustained.

Aboriginal health in South Australia in the 2000s

Within South Australia, the Generational Health Review specifically focused on the health concerns of and for Aboriginal people. The opening statement was headed Case for change – a national emergency and reported that;

‘Aboriginal people’s [ill] health in South Australia is totally unacceptable. There is no room for complacency. In no other population group are the social, economic and environmental determinants of health so well exemplified. Poverty with poor diet, poor lifestyle, stress and anxiety is a major cause of poor health.

(Government of South Australia 2003a, p. 1)

The report highlighted that there had been few health improvements over the last ten years and that poor life expectancy, infant mortality, and the prevalence of chronic conditions were unacceptably high. Socioeconomic factors of lower education, low income, high unemployment and incarceration rates were seen to impact on Aboriginal health and well-being, reflecting a focus on recognising comprehensive primary health care and the impact of poorer leels of social determinants of health.

The review reported that only 0.6% of the state health budget had been spent on specific Aboriginal health services and this had not met the complex needs of many Aboriginal people, who comprise 1.6% of the total SA population. A whole of government and health service response was promoted across justice, employment, education, housing and utilities departments. Aboriginal health was reinforced as being *everybody’s business*; rather than the concern of a few specific (often under resourced) Aboriginal health services (Government of South Australia 2003a). *Everybody’s Business* became the re-badged version of inter-sectorial collaboration.

During Generational Health Review interviews, Aboriginal people spoke of the systemic discrimination they encounter within the health system (Government of South Australia 2003b). Racist attitudes of staff members, discrimination toward Aboriginal staff, restricted access to mainstream services and short term and spasmodic funding were all identified as preventing equitable care. Aboriginal people advised that their community controlled primary health care

services were more culturally responsive services, were most able to meet their complex needs, and were therefore the preferred option¹². While mainstream options and choices were important, many preferred to attend Aboriginal health services (Government of South Australia 2003b).

The struggles of community based Aboriginal health services

Within the complex environment of mainstream biomedical dominance and Aboriginal focused comprehensive primary health care funding and policy priorities, Aboriginal Health Services and Community Health Services (ACCHS) have struggled to meet Aboriginal client needs. Aboriginal health services in particular have raised concerns related to Federal 'body part' funding for primary health care programs (Henry et al 2004). Separate streams of money are provided for each differing (biomedical /technical) condition such as diabetes, heart disease, and asthma. One Aboriginal medical service reported that they had to apply, set up separate accounts for, monitor and provide reports and evaluations to twenty six different funding streams to meet clients' needs (Henry et al 2004, p. 517). In Perth, an Aboriginal Medical Service experienced a funding cut when an 'overspend' arose due to their success of attracting additional Aboriginal clients. At the same time a teaching hospital overspent 120 times as much and were given an extra \$100 million to cover their overspend (Henry, Houston & Mooney 2004, p. 517). This highlights the value and authority that continues to be placed on tertiary care and biomedical knowledge over primary health care, even in the area of Aboriginal health that has strong policies supporting the need for both comprehensive primary health care and selective primary care.

Women's health

Australia's first **National Women's Health Policy** was developed in 1989¹³, with a vision of improving the health of all Australian women. Underpinned by social justice, comprehensive primary health care and feminist ideology, this

¹² The history of Aboriginal Community Controlled health services in South Australia is unique in that several of them (including Pika Wiya and Ceduna Koonibba) are not really community controlled as their board members are appointed in the main. Generally ACCHS started through community initiatives to address exclusion from mainstream and obtained funding overseas.

¹³ The same year as the first National Aboriginal Health Strategy.

policy focused on describing and developing solutions to Australian women's health needs (Black 2007; Commonwealth Department of Health Housing Local Government and Community Services 1989). Strategies included health promotion and prevention, consumer information, community development, equity and access to appropriate and affordable services. Differences in health status and health outcomes were seen to be linked to gender, age, socioeconomic factors, ethnicity, disability, location and environment rather than on individual behaviour and actions. Women's participation and rights as health consumers, health carers and decision makers were recognised (Black 2007). Consideration of social, environmental, economic and biological factors signalled a considerable paradigm shift from a biomedical to a social model of health. Women's health centres and teams increased throughout South Australia in response to the policy and Federal funding. Multidisciplinary women's health programs focused on comprehensive primary health care and addressing women's priorities. Some programs focused specifically on Aboriginal women's needs.

At the Third National Women's Health Conference in 1995, delegates reflected on whether the National Women's Health Policy had in fact followed a social model of health with some arguing that it was focused almost entirely on the health care system and did not extend its influence to other policy areas that strongly effect health, such as housing, education and economic (Beaumont 1995). It was noted that the policy did not produce equal gains for Aboriginal women and a recommendation was made that a specific National Aboriginal and Torres Strait Islander Women's Health Policy and funded program be implemented. However, with the change of government, and an increasing emphasis on selective primary care and mainstream services, Aboriginal specific and women's health services and programs were drastically de-funded, and programs re-directed to mainstream services (Rogers-Clark 1998). This meant that the few comprehensive primary health care programs that focused on the specific needs of Aboriginal women were also de-funded. Another round of collaboration and relationships between health services and Aboriginal community women was built up, and then dismantled.

In 2005, the South Australian Government (2005) released a Women's Health Policy as a specific focus of state health reform. Within it, the government recognised women's roles in strengthening economies, creating inclusive societies, and developing responsive and effective health services. The health system was to become more accessible, safer, equitable, flexible and responsive to women, based on the belief that by improving the health of all women, the health of the whole community would improve (Government of South Australia 2005). Women were recognised as the majority of health consumers, health service providers and carers in South Australia. Increasingly responsive services to address women's physical, mental, emotion and social health issues were promoted.

Aboriginal women were specifically recognised as having the least access and worse health outcomes of all women in South Australia. An emphasis on full participation and leadership of Aboriginal (and Torres Strait Islander) women in the health system and in Aboriginal communities was made. Increased access, employment and training, and culturally respectful services that identified and eliminated discriminatory practices were cited as steps toward increased participation (Government of South Australia 2005). The extent to which these intentions have been realised at the practice level are discussed in Collaboration Areas One and Two.

Summary

This chapter has discussed the primary health care, Aboriginal health and women's health policies and practices that have influenced Aboriginal women's health care in community health settings in South Australia over the last forty years. The changing emphasis on biomedical/clinical illness based services, and comprehensive primary health and social determinants of health, reflect vastly different underlying beliefs about the value of knowledge sharing, collaboration and community participation. Aboriginal communities, organisations and policies, and women's health policies continue to identify and promote comprehensive primary health care as the approach that can best meet the complex health needs of Aboriginal women and their families.

However the ability of health services to provide this form of care fluctuates with different state, federal and international policies and strategies.

The following Figure 3.1 shows the relationship between the aspects of health care discussed in this chapter with the three central themes of knowledge sharing, working together and addressing issues.

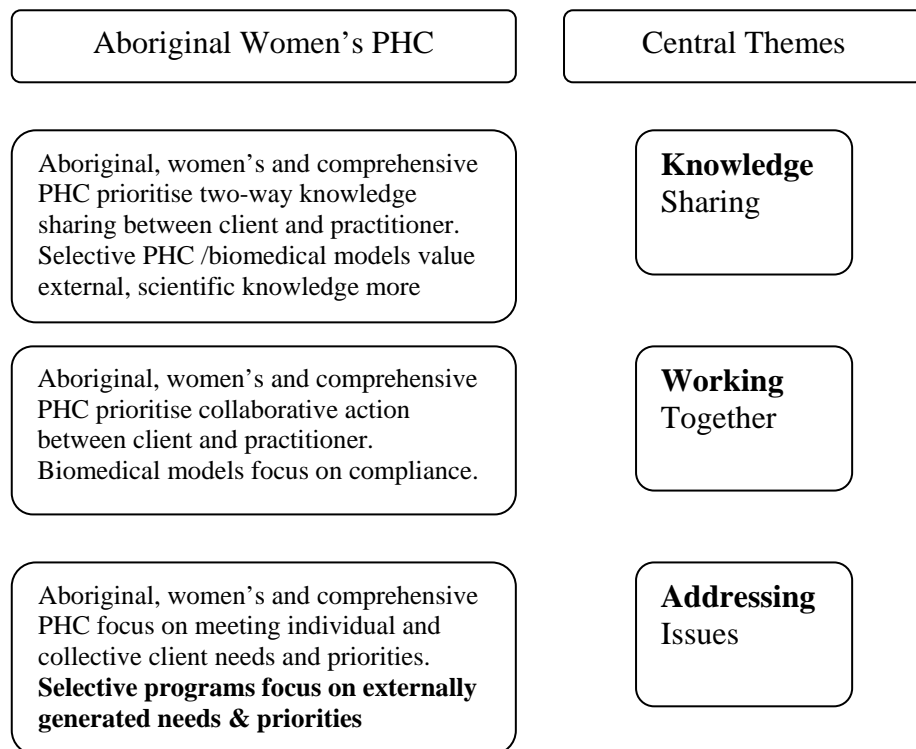


Figure 3.1 Different levels of knowledge sharing, working together and addressing issues in different approaches to health care

In the next chapter, I explore more deeply these three central themes of knowledge sharing, working together and addressing issues, and the theoretical perspectives that underpin them.

Chapter 4 Theoretical Perspectives

In this chapter I provide a deeper discussion of the three central collaboration concepts of knowledge sharing, working together and addressing issues. I begin by explaining Western concepts of communication and knowledge interests, and Aboriginal concepts of Ganma two-way knowledge sharing across cultures and Dadirri deep listening. I discuss how the treatment of particular people as ‘Others’ and the privileging of one form of knowledge over another can interrupt knowledge sharing, particularly in Aboriginal women’s health settings. The second section explores how respectful and democratic knowledge and power sharing can strengthen Aboriginal women’s and health professionals’ voice, organisation and action and lead to more effective collaboration. The concepts of liberation and community development are presented as specific strategies that can assist people to improve their life situation, health and well being. The third section focuses on addressing issues of colonisation and health care access. I describe how concepts from postcolonial feminism and cultural safety can be used together to counter discrimination and enable health professionals to better meet clients’ needs. I review concepts of evidence based practice and question what forms of knowledge are included in this process. I then argue that in order to provide culturally safe care, health professionals need to (be supported to) recognise and utilise subjective, professional, client focused and cultural knowledge and priorities as well as external, objective biomedical / technical knowledge. I begin by discussing knowledge sharing as the basic building blocks of collaboration and culturally safe health care.

Knowledge sharing

As discussed in the previous chapters, many Aboriginal community women, health professionals and policies have identified the importance of knowledge sharing and a collaborative partnership approach toward health care, in order for meaningful health improvements to occur. Colonising, discriminating and exclusionary practices have involved, and continue to involve, one way and/ or disrespectful communication, and the use of power over another. In order to

heal this situation, health practitioners need to find ways to work effectively with Aboriginal clients that involve knowledge and power sharing.

Ideal speech and knowledge interests

Within Western literature, German philosopher Jürgen Habermas (1972; Habermas) has been influential in promoting the importance of effective, non-dominant communication and the ‘*ideal speech*’ situation’. He described this as involving true consensus, mutual understanding, equal opportunities to talk and listen, openness and authenticity, the right to participate, and as a consequence, the generation of new knowledge. This concept of ideal speech is a fundamental aspect of effective primary health care.

Habermas (1984) stressed that all people are capable of making rational decisions based on their own knowledge and self-reflection, but that differences in intention, wealth, status, knowledge and power can interfere with effective and equal communication. He developed the concept of *knowledge constitutive interests*, proposing that people take a specific approach to knowledge development depending on their underlying interests. He claimed that people had three fundamental interests or levels of knowledge making; these are technical, practical and emancipatory. *Technical* interests require empirical, objective and analytic approaches to knowledge development, breaking things down into small parts so that they are understandable. They are grounded in experience and observation, produced through hypothesis and experimentation, and aim to control situations. In the primary health care setting, technical interests involve biomedical scientific knowledge that enables health professionals to provide quality clinical services and advice, such as women’s health screening and interpretation of results.

Practical interests relate to interpretive approaches, underpinned by communication, understanding and moral considerations. Habermas believed that a fundamental need of humans is to live in and be a part of the world and society, and not to be in competition with others for survival (Grundy 1987; Habermas 1972, p. 208). Practical interests promote subjective meaning making rather than objective observation, assisting health professionals to move from questioning ‘what can I do’ to ‘what ought I do’ within a particular

situation. Health professionals are encouraged to engage in practical reflection, considering their own and other people's lived experiences, and how this is communicated and interpreted by each other. It enables health care to become more responsive to individual client needs.

Emancipatory interests involve self reflection, autonomy and responsibility. It begins as an individual experience, but is inextricably linked with the freedom of others, justice and equality. Habermas described self reflection as *at once intuition and emancipation, comprehension and liberation from dogmatic dependence* (Habermas 1972, p. 208). Using emancipatory interests, health professionals become aware of possible 'coercion' involved with technical interests, linked to limited options, professional knowledge dominance and expected compliance. They also recognise limitations of practical interests. Even when everything appears to be consensual within a group, external forces may be manipulating the situation. Emancipation and critical reflection enables health professionals to consider and critique the wider agendas that may exist between and around the health care encounter, and may impact on a clients' ability to achieve better health and well-being. This includes the ability of individuals and groups to take control of their own lives and to take positive action to reach their own goals, as was discussed in the Aboriginal Health Strategy (Grundy 1987; Habermas 1972, p. 208; National Aboriginal Health Strategy Working Party 1989).

Habermas's (1972, p. 208) work assists primary health care professionals to identify different aspects of communication within selective primary health care (often health professional dominant) and comprehensive primary health care (knowledge sharing between health professionals and clients). While this is useful for primary health care generally, there are additional factors to be considered in health care involving Aboriginal people in Australia. As discussed in Chapter Two, significant challenges to respectful communication and knowledge sharing between non-Aboriginal and Aboriginal people exist in Australia. In order to improve communication in cross cultural interactions, I need to consider knowledge generated from an Aboriginal perspectives.

Ganma knowledge sharing

The Yolgnu people of Arnhem Land in the Northern Territory of Australia have described genuine two-way sharing of knowledge between Aboriginal and non-Aboriginal peoples as *Ganma*. They have chosen to prepare and share this cultural knowledge with non-Aboriginal people in Australia and overseas in the belief that it could help improve relations between Aboriginal and non-Aboriginal people (Hughes 2000; Pynch & Castillo 2001; Yunggirringa & Garnggulkpuy 2007). Therefore, *Ganma* was readily accessible in the literature in a form already approved and accepted by the Yolgnu community¹⁴.

The Yolgnu people describe what happens when two different kinds of water or knowledge meet and mix together.

*A river of water from the sea (Western knowledge),
and a river of water from the land (Aboriginal knowledge)
mutually engulf each other upon flowing into a common lagoon and
becoming one.*

*In coming together, the streams of water mix across the interface
of the two currents and foam is created.*

This foam represents a new kind of knowledge.

Essentially, Ganma is a place where knowledge is (re) created

(Hughes 2000; Pynch & Castillo 2001; Yunggirringa & Garnggulkpuy 2007)

They explained how people from differing cultures and backgrounds can share deeply without losing their integrity. They explain that water, like knowledge, has memory. *When two different waters meet to create Ganma, they diffuse into each other, but they do not forget who they are, or where they came from* (Pynch & Castillo 2001, p. 380). To give up or ignore one's history is to risk losing one's integrity; strength comes from understanding where we have been (Pynch & Castillo 2001; Yunggirringa & Garnggulkpuy 2007). *Ganma* thus provides a conceptual framework for Aboriginal and non-Aboriginal people to

¹⁴ It is very important that this Traditional intellectual cultural knowledge has been voluntarily and purposefully shared by the Aboriginal community concerned, rather than taken in colonising practices. I was able to personally seek permission to use *Ganma* in this thesis when two Yolgnu women attended the Action research conference in the fourth Collaboration Area, and observed my research approach in action. I also sought permission from local Karna Elders to use Aboriginal knowledge from another region to guide this research. We identified that Karna people had similar concepts of knowledge sharing, but that the cultural processes necessary for local Aboriginal knowledge sharing concepts to be respectfully utilised in this project were not yet finalised.

work collaboratively with each other in post-colonial Australia, mindful and in respect of, our separate and combined experiences.

Ganma influences interactions, providing ways for people to connect and work with each other more deeply and respectfully, creating new knowledge that is not *yours* or *mine* but *ours*. The Yolngu people say that if we try to capture the collaborative knowledge/ foam in our hands it evaporates; it is only through gently holding the foam that it lingers, revealing itself to us. If we force it, it disappears (Pyrch & Castillo 2001; Yunggirringa & Garnggulkpuy 2007). Creating foam requires more than a joining of intellect and egos. In order to hear the quiet sounds of foam, one needs to listen with one's heart, *to be aware of the experiencing not just the experiences* (Yunggirringa & Garnggulkpuy 2007). Similarly, the Kurna and Ngarrindjeri Elder women told me that *unless you can join us with both your head and your heart; you will do no significant work with us* (Aboriginal Women's Reference Group 2005). The Ganma process provides a vision of how we can deepen our understanding of who we are, what we have to offer, and how we can engage with others in respectful relationships in postcolonial Australia (Pyrch & Castillo 2001; Yunggirringa & Garnggulkpuy 2007). The first step involves listening respectfully to each other.

Dadirri listening to one another

Many Aboriginal people describe the importance of deep respectful listening and building connections with each other. The Elder women told me;

you sit and listen to us, so we tell you things we wouldn't tell other people. You listen and show respect, and in return we listen and show respect- it goes two-ways (Aboriginal Women's Reference Group 2005).

Similarly, Judy Atkinson (2002), a Jiman and Bundjalung descendant with Celtic-German heritage, discusses the important role that deep listening has in healing and positive change in postcolonial Australia. She refers to the concept of Dadirri, an inner deep listening as shared by Ngangikurungkurr people and in particular, Miriam Rose Ungunmerr of the Daly River area in the Northern Territory.

Dadirri is described as a quiet, still awareness, similar to contemplation (Ungunmerr 1993). It is a non-obtrusive observation, a quietly aware watching, where people are recognised as being unique, diverse, complex and interconnected; part of a community where all people matter and all people belong (Atkinson 2002; Ungunmerr 1993). Atkinson (2002, p. 15) describes Dadirri as;

a reflective non-judgemental consideration of what is being seen and heard; and, having learnt from the listening, a purposeful plan to act, with actions informed by learning, wisdom, and the informed responsibility that comes with knowledge.

This concept links with respectful and democratic knowledge sharing described later in this thesis in critical and feminist theory and community based action research. Dadirri offers a deeper understanding of how to develop the kind of deep listening that many Aboriginal women request. Atkinson advises that we first need to listen quietly, in order to gain trust and respect.

I will listen to you, share with you, as you listen to, share with me.....

Our shared experiences are different, but in the inner deep listening to, and quiet, still awareness of each other, we learn and grow together. In this we create community, and our shared knowledge(s) and wisdom are expanded from our communication with each other (Atkinson 2002, p. 17)

In many ways Dadirri explains how deep listening enables Ganma knowledge sharing to occur. Atkinson describes Dadirri as an inward as much as an outward journey, a self awareness of one's own *beliefs, influences, assumptions, intrusions, decisions and a choice*, and how these impact on health care and research. Atkinson describes how Dadirri guides her to *act with fidelity in relationship to what has been heard, observed and learnt* (2002, p. 18), to understand the pain beneath anger, what a body says when a tongue cannot, and to listen with her heart as well as her ear. Dadirri encourages practitioners to affirm the courage and hope of people, to move beyond common understandings of reciprocity, responsibility and support, toward a deeper understanding that enables all involved to find new meanings in their

experiences, and a restructuring of stories (Atkinson 2002). Dadirri adds another layer of healing and responsiveness to knowledge sharing.

Challenging ‘Othering’ behaviours

As described above, emancipatory knowledge interests, Ganma and Dadirri all require self reflection, self awareness, and a willingness to *engage with* other people. Colonising, discriminating and exclusionary practices involve designating *The Other* person as something different to the unspoken norm. Haraway (1988) describes this as a ‘God Trick’ used by many writers, to describe and paint the *Other* from a position of “no-where”. Critical, feminist, third world, postcolonial and Indigenous writers have critiqued health carers, researchers and feminists who have a tendency to speak *of* and *for* ‘Others’ while occluding (hiding) themselves and their own investments and agendas (Bhabha 1992; Chinn 2003; Fine 1994; Fine, Weis, Weseen & Wong 2000; Frankenburg 1993; hooks 1990; Ladner 1971; Moreton Robinson 2002, 2003). Western colonial literature has often followed a trend of highlights the issues of *The Other* while hiding the writer’s own agenda (Fine 1994). In the words of hooks (1990, pp. 151 -2);

No need to hear your voice when I can talk about you better than you can speak about yourself. No need to hear your voice. Only tell me about your pain. I want to know your story. And then I will tell it back to you in a new way. Tell it back to you in such a way that it has become mine, my own. Re-writing you, I write myself anew. I am still author, authority. I am still the coloniser, the speak subject, and you are now at the centre of my talk

Othering such as this disrupts the respectful intention within Ganma knowledge sharing and Dadirri deep listening.

Feminists such as Chinn (2003) promote the concept of embodiment in recognition that we all live in a particular body, and operate from a particular standpoint. Who we are and what we believe impacts on the way we live, work, provide health care, research and write. Fine (1994) describes the link between self and other as a *hyphen*, a space we can use to separate or merge our personal identities with our inventions of *Others*. These concepts encourage health professionals to become more aware of their integrity in

relationships with others and whether they work with people in equal collaboration, or if they consciously or unconsciously delegate them to the position of 'Other'. In health encounters involving people from a significantly different culture (such as Aboriginal and non-Aboriginal) this can be particularly challenging.

Permeability and cultural exchange

Maori researcher Matairea (2003) explores the intricacies of knowledge exchange across cultures by introducing the concept of permeability. He argues that it is difficult to understand another culture by merely observing it; rather trust and respect need to be built over time. He proposed three layers of interaction and understanding that occur when people from two different cultures interact, in particular, when the outsider is a non-Indigenous person working with Indigenous peoples (Matairea 2003).

The outer sphere or 'outsiders view' is where the outsider first encounters a new culture and experience unfamiliarity, a disconnectedness and lack of understanding. The outsider formulates their own opinion and assumptions based on their subjective interpretation of food, language, housing, fashions, artwork and ceremonial activities. From an Indigenous point of view, this layer is what outsiders understand through ignorance, limited knowledge and limited insight. If there is genuineness in an outsiders attempt to learn, the Indigenous person may permit them into the next layer (Matairea 2003, p. 12).

The middle layer involves knowledge norms, moral beliefs, roles, responsibilities, expectations and values. Norms are the collective understanding people hold about what they see as right and wrong and values determine what constitutes good and bad. Social norms reflect the social values people collectively hold and provide stability to communities. When this is not evident, conflict and tension arise. While norms generate a cognisance of how people should behave, values tell us how we indeed should aspire to behave. Values therefore serve as a basis for choices (Matairea 2003, p. 13).

The inner layer involves learning about the values of another's core assumptions about how people construct their world. Interacting at this level involves learning about what we and others value and how we construct our

worlds. Only when outsiders begin to understand and make the necessary sacrifice will they gain sufficient trust among Indigenous peoples to undertake deeply interpersonal tasks such as health care and research (Mataira 2003, p. 13). This reinforces the two way partnership and trust needed for knowledge sharing; both people need to be prepared to become deeply aware of their own culture and beliefs, and how these impact on their interactions with others.

Mataira adds that *even Maori people who have been away from their communities too long endure a rite of passage* (Mataira 2003, p. 13). This is a timely reminder for mainstream and Aboriginal health services to not presume that just because a health professional is Aboriginal, they can automatically go in and work with another group of Aboriginal people. It may be that their cultures are significantly different or that the person has been separated from the people and culture for a long time and need to reconnect. Concepts of Cultural Permeability and Exchange highlight that Ganma and Dadirri processes may take time to occur, and may not be rushed to fit health system time frames.

Working together

Respectful and democratic knowledge sharing that strengthens people's voice, organisation and action can lead to effective collaboration (Freire 1972; Gaventa & Cornwall 2006). Social activists have long argued the link between knowledge, power and the ability to act. The ways that people view, hold, generate and/or share knowledge and power determines the kinds of action and collaboration that is possible. Gaventa and Cornwall (2006) describe four dimensions of power that impact on knowledge sharing and participative action. The first three consider knowledge in relation to domination, conflict and control, with knowledge *being in the hands of a monopoly of expert knowledge producers, who exercise power over others through their expertise* (Gaventa & Cornwall 2006, p. 74). Those who hold and wield power force others to do what they would not normally do, preventing inclusion in discussions and decision making, and controlling what is considered to be valid knowledge.

To counter this, community members or participants are encouraged by social activists to construct their own knowledge through a process of action and reflection, to become empowered (the fourth form of power). This process is described by Brazilian educationalist Paulo Freire as conscientisation and underpins concepts of community development. While Habermas theorised about communicative action, Freire (1972) put into action concepts based on moving from false consciousness to emancipatory knowledge and collaborative action. He particularly focused on critical awareness raising literacy programs at a grass roots level.

Liberation, power and collaborative action

Freire stated that people were always *in the process of becoming*, and that they have an intricate part to play in their own development. Similar to Habermas, he saw that people had imagination that enabled them to envision not only what is, but what could be. He proposed that if people could view their current oppressed situation as temporary and alterable they could change their own destiny (Freire 1972). Liberation was a key aspect of Freire's work. He believed that both the oppressed and the oppressors ultimately benefited from a move away from exploitation, oppression and all forms of injustice, toward working together and becoming more human. He saw two-way discussions, critical reflection and working together in action, as key elements of liberation. This engages with the fourth aspect of power discussed by Gaventa and Cornwall (Gaventa & Cornwall 2006) that views knowledge and power as complementary rather than competing.

In his adult learning programs Freire regarded both the learner and the educator as equal partners who both bring their knowledge (and power) with them in the learning process. He described two forms of education. Banking Education involved teachers 'depositing' knowledge in the 'learner' in a one way process without dialogue. The student was seen as merely an empty receptacle, there was little opportunity for growth, and the status quo was not challenged (Freire 1972). This form of education is more common in selective primary health care approaches where acceptance and compliance rather than knowledge sharing and collaboration are expected.

The second form of education, Dialogical Education involved both the teacher and student sharing their knowledge in equal partnership. The teacher became student and the student became teacher, enabling both teacher and student to be liberated by new knowledge (Freire 1972). This form of teaching is more closely aligned to that found in comprehensive primary health care, Ganma sharing of knowledge, and power sharing decolonisation strategies where health professionals and community development workers value and support community members knowledge and action. Freire began literacy processes with peasants by first asking them which words were significant in their lives, and what such words meant to them. In a health care setting, health professionals can similarly invite community members to discuss their understanding and priorities regarding health, health care and well being, as well as sharing their own. From this mutual understanding, responsive and collaborative action can be taken.

American psychologists and academic feminists Belenky, Clinchy, Goldberger and Tarule (1973) extended Freire's work by exploring how it related specifically for women from a range of backgrounds. They continued to use the term 'Banking Education' to describe old ways of learning where knowledge is bestowed upon students by a teacher, with all preparation work done before hand, and information delivered as a *fait accompli*. However, they used women centred terminology to describe liberating and empowering ways of learning that women preferred. They described *Midwife teachers* as those who supported the emergence of the student's own thinking, contributing as needed, always recognising and promoting the student's own thoughts. They then described *connected teachers* as those who nurtured student's thoughts to maturity, with understanding that uncertainty was part of the process. They welcomed diversity of opinion and open discussion, and refrained from 'inflicting' their opinions on their students, rather acting as short-term partners and facilitators of knowledge gain (Belenky et al. 1973). A connected teacher had the ability to present herself as a space where subjectivity and objectivity merge. For a brief period, the teacher and student could meet on common ground, and truly 'be' with the other. Connected teachers were believers in that they trusted the student's thinking and encouraged them to expand on it.

Belenky et al (1973) suggested that connected models helped women embrace their own community, power and integrity and take action.

These feminists also identified that many women valued 'real learning' gained through relationships, life crises and community involvement rather than through academic learning and interactions. They surmised that male dominated perspectives, visions, theories, history and values were biased and did not reflect women's preferred ways of interacting, understanding and learning. The strong Western emphasis on rationalism and objectivity (similar to Habermas's technical and rational interests) underpinning most methodologies, theories and disciplines devalued emotional, intuitive and personalised thinking (Belenky et al. 1973). These findings are mirrored in the National Women's Health Strategy (Commonwealth Department of Health Housing Local Government and Community Services 1989) that emphasised the importance of women centred action and health care.

These concepts about knowledge, power and collaborative action described by Freire and Belenky and colleagues highlight important aspects needed for effective collaboration in Aboriginal women's health care. Health professionals are reminded to work *with* Aboriginal community women as equals, sharing knowledge in respectful Ganma type exchanges. Where possible, health professionals can take the role of Dialogical, Midwife or Connected teacher, supporting and encouraging women to trust and grow their own knowledge about what is best for them. These forms of interaction are found within community development, partnerships and comprehensive primary health care approaches that take action to collaboratively address issues.

Addressing Issues

There are two main aspects of addressing issues explored in this thesis. The first involves addressing issues related to colonisation, discrimination and exclusionary issues as discussed in Chapter Two. The second involves addressing issues related to health care access for Aboriginal women that stem from particular policies and practices as discussed in Chapter Three. I argue the two are inextricably intertwined. In Australia today, the impacts of colonisation

continue to have a major negative impact on Aboriginal women's health and well being, and these past and present experiences influence their health care seeking behaviour today. A range of critical theories about the legacy of colonisation have been developed and are called 'postcolonial theories'.

Postcolonial perspectives

The title has 'postcolonial' has led to confusion, with some perceiving that it refers to a time when colonisation is *over* (Aboriginal Women's Reference Group 2005; Ramsden 2002). For theorists such as Said (1978) and Ashcroft (2001a) however, postcolonial refers to a time after colonisation began. When I use the term postcolonial I am referring to the time after colonisation has *begun*, where past *and ongoing* effects of colonisation exist. This interpretation of postcolonial as colonisation being a continuing process has guided this research and thesis. For example in the second chapter colonising experiences of racism and exclusionary practices experienced by Aboriginal women in past and present forms are discussed.

Battiste (2004) defines postcolonial as a strategy that responds to experiences of colonisation and imperialism and a critique that rethinks the conceptual, institutional, cultural, legal and other boundaries that are taken for granted and assumed universal but *act as structural barriers to many, including Aboriginal people, women, visible minorities and others* (Battiste 2004, p. 1). Postcolonial discourse focuses on relationships within, and the effects of, colonisation (Kirkham, Baumbusch, Schultz & Anderson 2007). While recognising the hugely negative impacts of colonisation overall, most contemporary postcolonial writers avoid an oversimplified definition of people as either 'the colonised' or 'the coloniser', because to do so hides the complexities and ambiguities of social locations and shifting capacity for resistance and agency that also exist (Ashcroft 2001b; Browne, Smye & Varcoe 2005). Rather multiple perspectives and positions are considered. The person who has the power in any relationship may not be as transparent as it seems because at any time, people may occupy multiple positions with many different interactions occurring with and around them (Anderson, J 2004). There may be both negative and positive aspects intertwined. Battiste (2004, p. 2), a Mi'kmaq educator describes the importance of recognising;

...not only the criticism and deconstruction of colonisation and domination, but also about the reconstruction and transformation, a liberation of colonial imposition.

This recognises the dynamic nature of change, action and reaction in postcolonialism, and the potential for liberation and decolonisation. Ashcroft (2001a) similarly argues that in order to understand past, continuing and future aspects of postcolonialism, it is necessary to understand political resistance and the dynamic nature of cultural transformation.

Post colonial resistance and transformation

Ashcroft (2001b) describes three specific forms of resistance and transformation that exist within postcolonial settings. The first is *political opposition* or *open resistance* that involves violence and warfare. In response to colonial invasion, local people fight back. This was seen in many areas of Australia as frontier violence (Eckermann et al. 2006). In a health care situation this can be seen when Aboriginal people 'fight the system' by vocalising their frustrations of a system that does not meet their needs. A second less violent expression of resistance is *passive resistance*. Ghandi used passive resistance in India to counter the colonial British Raj (Ashcroft 2001b). In a modern health care setting this may be seen when an Aboriginal person actively chooses not to attend a specific health service. This does not include experiencing difficulty with getting to the appointment, conflicting priorities, or issues related to childcare or being a carer for other family members, but rather a genuine rejection of the service based on values, beliefs or political opposition. A third form of resistance is a *refusal to become absorbed* by the incoming culture and society. Colonised peoples have repeatedly taken Western ways and influences, and transformed them into tools with which they can use for their own purposes, culture and identity (Ashcroft 2001b). In a health care setting, Aboriginal people may choose to attend a community controlled Aboriginal health service that is governed by the community, and provides Aboriginal focused services, rather than attend a mainstream service.

Ashcroft suggests that this last *transformational* aspect of resistance is used by ordinary everyday people to great effect. In many ways it is more powerful

than open resistance because people refuse to become trapped within the colonial binary of who is colonised and who is the coloniser, who has power and who does not, who is civilised/ uncivilised, black/white (Ashcroft 2001b, p. 21). When a group openly resists they 'buy into' a colonial binary. But when they resist by quietly transforming the 'colonial ways', they step out of this opposition and create something new and unique. Working in partnership and sharing knowledge across cultures can become part of transforming decolonisation.

All three forms of resistance have continued to be employed by Australian Aboriginal peoples over the last two hundred years at different times (Eckermann et al. 2006). Which form is used may depend on the setting, issues faced, and people involved. Knowing this assists health professionals to understand that there may be a range of ways that (community and health professional) Aboriginal women express their strengths, challenges, resilience and ingenuity, and that these may vary depending on their experiences, levels of frustration, and how safe and respectful a health encounter is for them.

Whose voice?

Worldwide, Indigenous peoples are adding their voice to postcolonial discourses, developing postcolonial knowledge based on Indigenous ways of knowing, worldviews, research processes and experiences (Battiste 2000; Smith 2003). This Indigenous knowledge needs to be recognised and respected as valid by the wider community without being appropriated. In the Ganma two-way knowledge sharing metaphor, freshwater Indigenous knowledge swirls with salt water Western knowledge, intermingling, but not losing its origins. Similarly, Indigenous postcolonial knowledge needs to swirl with Western postcolonial knowledge but not be consumed by it. Browne et al (2005) reinforce this viewpoint suggesting that Indigenous knowledge can (and should) be used to inform wider postcolonial theories, as long as it is recognised that Indigenous epistemologies represent different intellectual endeavours (Browne et al 2005). While Western and Indigenous epistemologies (ways of thinking) are often used together or in parallel, it is important to distinguish between the two positions and how they interact in relation to a history of Western dominance. Postcolonial Indigenous discourse

not only *stems from Indigenous knowledge*, it also challenges non-Aboriginal people to re-evaluate their colonial frameworks of interpretation, portrayals and inclusion or exclusion of Indigenous knowledge (Rocque 1996; Smith 2003). Battiste argues that Indigenous postcolonial thought emerged because of an inability of Eurocentric theory to *deal with the complexities of colonialism and its assumptions* (Battiste 2000). Therefore, it is important that Indigenous postcolonial theory and Western postcolonial theory are used together in the interests of knowledge sharing and finding new ways of moving forward together. Postcolonial theory therefore assists health professionals to work beyond the unconscious assumptions they may have. Although postcolonial theories are relatively new, they *provide a powerful analytical framework for considering the legacy of the colonial past and the post-colonial present as the context in which health care is delivered* (Browne et al 2005, p. 17). In order to specifically work in the area of Aboriginal women's health care, there is another aspect that is useful to add to postcolonial theory, and that is feminism.

Postcolonial feminism

Combining postcolonial theory with aspects of feminism and critical theory creates a powerful analytical framework that enables a consideration of gender, class, socioeconomic and power differences in many forms, as well as in relation to colonisation. Canadian nurse researchers Browne et al (2005) define postcolonialism as a theory that *'describes issues of domination and colonisation, race, racialisation, culture and 'Othering'* in Indigenous health and other settings. When combined with feminism it creates a broader humanistic approach enables health professionals to work respectfully with Aboriginal women, exploring complex and multiple aspects of health care and equity within contemporary societies (Browne et al 2005, p. 21).

Australian postcolonial feminist educator McConaghy (2000) similarly advocates for a balance between using social categories such as colonisation, gender, age, skin colour, occupation and class to explore and explain shared experiences of people experiencing similar social and historical events, and stereotyping people as being those who are marginalised, disadvantaged and / or victims by virtue of their social or racial standing. She suggests that it is better to understand the nature of *specific oppressions at specific sites*. By

widening the theoretical possibilities from *post-colonial* with an emphasis only on colonisation, to *postcolonial feminism*; there is less risk of making assumptions about what is happening in a health care encounter. The danger in presuming that there is a shared experience of colonisation among Aboriginal women is that health carers and researchers can overlook important differences, unique experiences and personal agency. This can occur within postcolonial feminism itself. Aboriginal postcolonial feminist Moreton Robinson (2002) strongly critiques white Australian feminist practices and writing in relation to Aboriginal women because of the total exclusion of issues of race in the analysis; post colonial feminism may not always address race.

In contemporary Australia (as in Canada), both Aboriginal and non-Aboriginal, health professional and community women are situated in complex and ambiguous positions, experiencing differing levels of capacity, resistance and agency at different times and in different situations (Browne et al 2005; McConaghy 2000). Complex relationships and changing dynamics exist within Aboriginal women's health and well-being and health care provision as has been discussed in chapters two and three. Postcolonial feminism encourages health professionals to work in collaboration with community women toward finding ways of addressing health inequities in active, pragmatic and culturally safe ways. It increases awareness that *the past is present in every moment of every day, in every policy and practice and in the language that we use* (Browne et al 2005) and that through recognising and positively addressing the complexities and inequities that exist, we can find positive ways to move forward together. One example of this, developed in nursing, is cultural safety.

Cultural Safety

Maori nurse Irihapeti Ramsden (2002) developed a model of culturally safe practice and education underpinned by social justice, critical, feminist, and neo colonial (postcolonial) theories¹⁵. Cultural safety promotes a respectful

¹⁵ Ramsden herself stated that she did not believe New Zealand had reached a state of postcolonialism when Indigenous people were still struggling with colonisation issues and institutional discrimination (interpreting postcolonial to mean 'after colonisation is over'), and preferred to use the term neo-colonial to postcolonial (2001a).

partnership between a client and a nurse/midwife based on negotiation and the sharing of knowledge and power. It provides a framework for nurses to critique their own practice, and consider how culturally safe their clients perceive the care that they have received.

A broader definition of Cultural Safety, adopted by the New Zealand Nursing Council was;

The effective nursing or midwifery practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation, gender, sexual orientation, occupation and social status, ethnic origin or migrant experience, religious or spiritual beliefs, and disability.

The nurse or midwife delivering the nursing or midwifery service will have undertaken a process of reflection on his or her own cultural identity and will recognise how the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises of any action which diminishes, demeans or dis-empowers the cultural identity and well-being of an individual. (Nursing Council of New Zealand - Te Kaunihera Tapuhi o Aotearoa 2002, p. 7)

This definition maintains a critical focus on moving beyond cultural awareness and cultural sensitivity, claiming that confining learning to rituals, customs and practices of a group in a 'checklist' approach, does not alert a practitioner to the complexity of human behaviours and social realities. Cultural safety education remains focused on the *knowledge and understanding of the individual nurse or midwife rather than on attempts to learn accessible aspects of different groups*. This is based on the belief that *a nurse or midwife who can understand their own culture and theory of power relations can be culturally safe in any context* (Nursing Council of New Zealand - Te Kaunihera Tapuhi o Aotearoa 2002, p. 8). This is another example of enacting Ganma knowledge sharing.

Ramsden also saw the need for nurses to understand colonisation processes and effects, in order to realise that many Maori people viewed the health system with distrust, leading to avoidance of health care. She identified that many nurses and health carers brought with them (often unconsciously) their assumptions, stereotypes and prejudiced attitudes from the dominant society, leading to unsafe care for Indigenous peoples. She sought to find ways to engage nurses and other health professionals within the health system, alert them to the colonial past and present, but not lose them in historical guilt and its crippling emotional outcomes. She encouraged Pakeha (non Maori) nurses to not blame the victims of historical processes for their current plight, but to question the wider issues impacting on their ill-health, and to be open minded, flexible and self aware. Rather than caring for people *regardless* of their differences, she promoted the idea that nurses provide care *regardful and with recognition of* their differences and life circumstances (Ramsden 2002).

Although colonisation experiences vary from country to country cultural safety can be a suitable and pragmatic tool for enacting abstract postcolonial theorising into health care and research in countries like Canada and Australia (Browne 2005; CATSIN 2002) By shifting the focus away from cultural characteristic and differences as the source of the problem, cultural safety highlights the culture of health care and the ways that policies, practices and research approaches can be seen as colonising, discriminating and exclusionary. It shows us pragmatic ways to enact client centred care embedded in respectful knowledge and power sharing and effective collaboration in postcolonial settings.

As a means of illustrating this, I share an excerpt from my reflective journal.

A young Aboriginal woman came into a clinic asking about contraception. As with all my nursing interactions I tried to approach this consultation as a partnership that involved joint decision making where I bring nursing / western medical/ sexual health knowledge, and the client brings her personal life situation, lived experience and cultural knowledge. As we blend these together we come up with a plan of action that is unique and meets her needs. I tried to follow both verbal and non verbal cues throughout the consultation, recognising that verbal communication is only one part of the discussion.

I asked the young woman if she had any specific types of contraception already in mind (she didn't), and what her personal priorities were; was it highly effective contraceptive cover, addressing period problems, prevention of sexually transmitted infections etc. Did she prefer to take something orally every day or have a 'set and forget' method like an implant or injection? These questions I wove into the conversation (rather than firing them off one after the other as they are written here). Then we discussed any medical issues that may impact on her decision, and she indicated that she recently saw a doctor after she had 'blacked out' (fainted). I wondered aloud if it could have any impact on the kind of contraception she could choose and asked if she knew the reason for fainting. She looked at me carefully, and then after a moment said 'well actually, it ended up that it was about spiritual things not medical'. She explained that she saw a doctor and was told she was medically fit and healthy. After discussing with her family the situation that led to her fainting, she discovered that the event was linked to deeper cultural / spiritual things and was taken out bush for dancing and ceremony.

I felt that this was a turning point in the consultation and that what I said and did next would be very important. I could ignore this information, as being not relevant to our consultation, ask questions about her experiences which may not be appropriate for me to ask, or incorporate what she was saying into the consultation. From her conversation tone and non verbal communication, I felt that she had told me, the women's health nurse, as much as she wished to about this highly personal and spiritual experience. I wondered what to say when I remembered the advice of Ros Pierce, an Aboriginal mentor; *'if you don't know something, then ask'*. I was also aware of the other women waiting in the waiting room, and so there were some pragmatic time considerations.

I asked, 'with this spiritual side of your life, do we need to consider how contraception may affect that or visa versa? Is it important that you still cycle with the moon, because if you take the pill, or some of the progesterone's, your periods will come at times set by the contraception, not nature'? She said she was not sure, and would ask the Aunties (Elder women).

I then suggested that we could look at a range of options, so that she could take the information away, talk to whichever members of her family that she needed to, and think things over. She agreed that would be a good idea. I asked if she would like some condoms to provide contraceptive cover until she was able to make a fully informed decision. The young woman then volunteered that her partner was a Traditional man.

Again, I was not sure what the significance of this was for what we were discussing, so I asked if her partner was Ok with wearing condoms. She said she wasn't sure but would take some and see. I then shared information about sexually transmitted infections, suggesting that if she didn't need the information herself, she could share the information with friends or families as needed. We discussed that it is very hard for young people to get accurate sexual health information sometimes. We

had a very lively two-way conversation that involved me sharing my nursing/sexual health knowledge and her sharing her and her friend's experiences. At the end of the consult she thanked me for the time I spent with her. On reflection, we had both shared information and had benefited from our time together (Reflective journal 6 March 2005)

This interaction demonstrates how the client and I were able to share our knowledges and find ways to work collaboratively to ensure her personal and cultural needs were met. Using the Ganma metaphor, I was a 'white' community health nurse (salt water) who brought to the consultation knowledge about sexual health and contraception. The client was a young Aboriginal woman (fresh water) who brought to the consultation knowledge about her cultural and personal priorities and that of her family and Elders. Together we created new knowledge (foam) as the options swirled and intertwined throughout our discussion. The encounter was positive and transformative for us both. In order to work in this way, I needed to have the freedom and organisational support to recognise and respond to the young woman's needs. Working within a comprehensive primary health care model that valued both practitioner and client knowledge, and the ways that these knowledges came together, enabled me to provide culturally safe care. This raises questions about what is considered *valid knowledge* in health care encounters.

Evidence based practice –revisiting what constitutes knowledge

Quality health care is based on evidence based practice. *Evidence* is often considered synonymous with *scientific*. However, Canadian researchers Kirkham et al (2007) question the ways in which unmodified and unquestioned Western scientific evidence based practice is used in health care, arguing that it can limit a health professionals' ability to meet individual clients needs, particularly the needs of Aboriginal peoples with ongoing health disparities. While recognising that technical evidence based practice plays an important role in improving efficient and effective health care (biomedical model), if used unquestioningly and unmodified, it can promote a (colonising) *set recipe approach* that does not take into account the deep rooted social, economic and historical factors that underlay health disparities.

From a cultural safety perspective, a ‘biomedical knowledge only’ approach can lead to health care provision *regardless*, rather than *regardful* of clients’ priorities and experiences. In comparison, evidence based practice that combines technical knowledge with postcolonial feminist analysis enables nurses and others to utilise their knowledges and skills to provide high quality health care in culturally safe ways, in partnership with clients. This was highlighted in the reflective practice example above. This discussion raises questions regarding what is considered evidence and whose evidence or knowledge is considered valid in each situation, and by whom.

Summary

In this chapter I have explored more deeply the three central concepts of respectful knowledge sharing, working together in collaborative action, and addressing issues of health care access and colonisation. These three themes are the building blocks of our collaboration. They specifically address the impact of past and ongoing colonisation issues as discussed in Chapter Two, and work regardless and regardful of the fluctuating landscape of health care provision with changing levels of collaboration as discussed in Chapter Three. Knowledge sharing, working together and addressing issues can be used to co-create pragmatic, effective and culturally safe strategies within Aboriginal women’s health care. They assist practitioners toward providing holistic and responsive comprehensive primary health care

The purposeful and respectful combination of Western and Aboriginal theories has created a unique partnership approach that enables deeper exploration of the issues and possibilities within cross cultural health care encounters in postcolonial Adelaide. A consideration of people’s multiple perspectives and positions enable the complexities of health care to be explored, without (immobilising) blame being cast. Health professionals are encouraged to critically reflect on their own practice and beliefs, move beyond assumptions they may (consciously or unconsciously) hold, and work interactively with clients and the health system. The recognition of client, professional, community and external knowledges as all being valid in health care settings enables more responsive forms of evidence based practice to be supported.

The correlation between the three central themes and theoretical underpinnings are summarised in Figure 4.1 below.

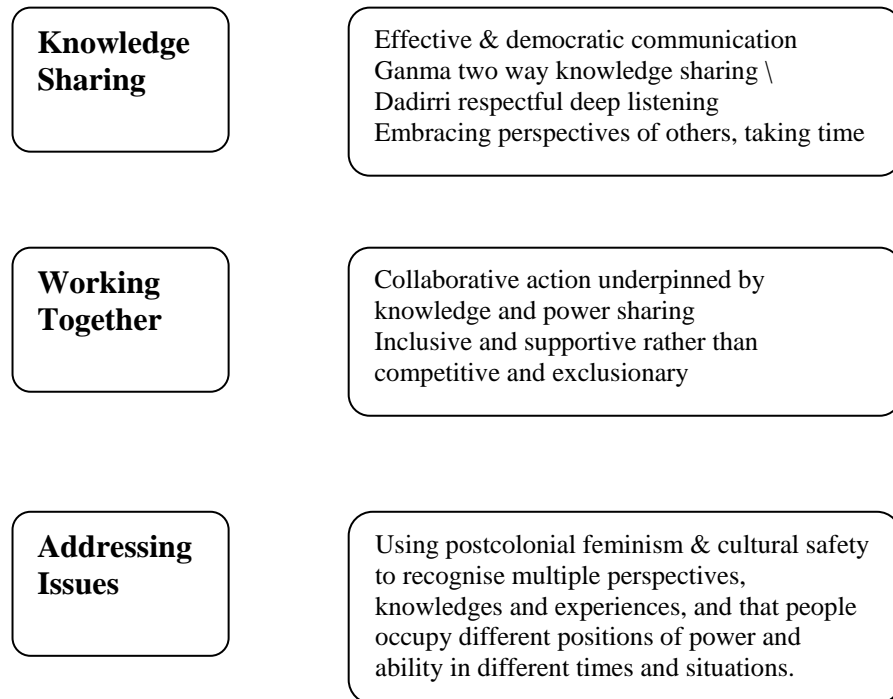


Figure 4.1 The three central themes of this research & theoretical underpinnings

These themes and underlying theoretical perspectives are used later in this thesis to explore the Collaboration Areas of the research and illuminate its findings. In the next chapter I argue how these concepts relate to Aboriginal health research. Just as knowledge and power sharing and collaboration and postcolonial cultural safety are important concepts for equitable and improved health care, so too are they critical for the application and utility of ethical decolonising research in contemporary Australia.

Chapter 5 Ethics & Methods

In this chapter, I discuss the design of this research, which is underpinned by the concepts of democratic two-way knowledge sharing, respectful collaboration and cultural safety as discussed in the previous chapter. Co-researchers, the Aboriginal Women's Reference Group and Aboriginal mentors were actively involved in the choice and development of the approach and methods used. I begin by discussing the need for deeply respectful Aboriginal health research, underpinned by concepts of reciprocity, respect, equality and responsibility. I discuss the priorities identified by the Aboriginal women involved with this research, and how these were incorporated into the research design. Using a post colonial, woman-centred approach, we adapted an existing participatory action research to co-create a research approach that was responsive to local needs. The three phases of look and listen, think and discuss and take action enabled us to put into action the central concepts of knowledge sharing, working together and addressing issues. Interviews, focus groups, literature review and analysis were all developed in ways that were respectful of these central themes, the women's personal preferences, and the need to counter colonising trends. Our emergent methodology developed and deepened during the research. This chapter discusses both the process (co-creating the research approach) and the outcome (our PAR model). I begin by discussing the importance of setting up research in the 'right way'; the ways preferred by the Aboriginal women involved.

Setting up 'right way' research

Research itself is not a new concept for Aboriginal people. Christine Franks (2002) a well known Aboriginal researcher in rural South Australia, suggests that Aboriginal people have been conducting research for thousands of years. She says;

It is evident the Aboriginal people have always done research...about the environment, where to go and when. They knew how to measure very precisely the numbers of people needed in groups for social, emotional, spiritual and physical well-being. It was very critical that research was

conducted and that it had to be a continuous process, because it was a matter of survival on a daily basis. So these discussions about health and social issues were conducted with the utmost integrity and intellectual rigour (Franks 2002, p. iv).

However, with colonisation came different forms and practices of Western research that Aboriginal people have learned to mistrust. As Smith (2003, p. 1) reflects, the situation today is that;

Research is probably one of the dirtiest words in the Indigenous world's vocabulary.

Until recently, Aboriginal people have been subjected to repeated instances of highly intrusive, exploitative, Eurocentric research and analysis without informed consent or obvious benefits to them as individuals or communities. Aboriginal Researcher Kim O Donnell discussed her uncle's experience of colonising research in rural New South Wales in the 1970s (2006b). She said;

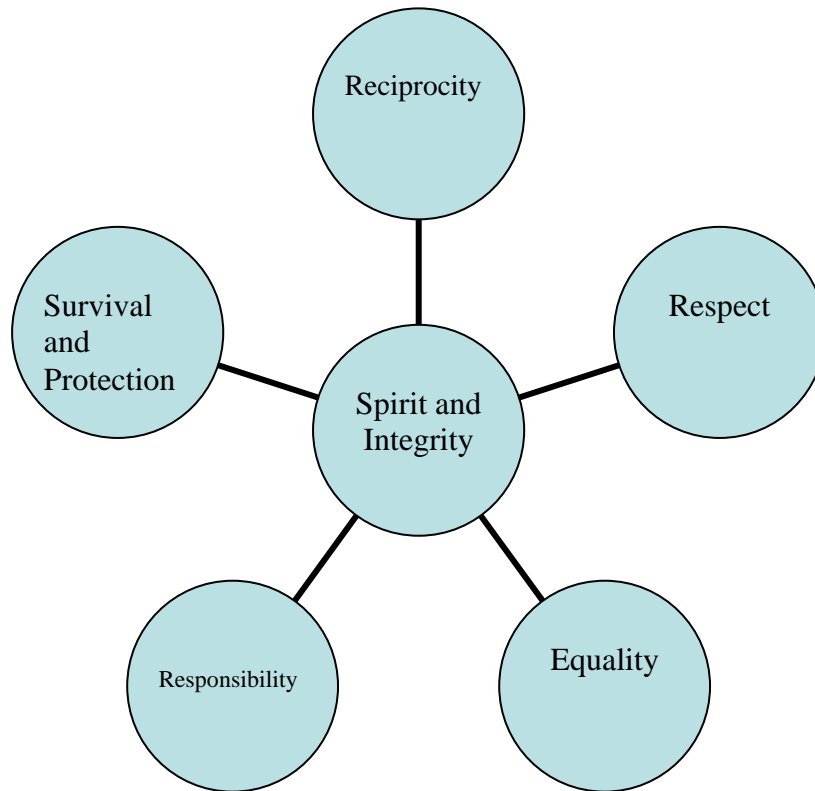
Research is a dirty word for many Aboriginal people because of the disrespectful and intrusive ways it was conducted. For example, my aunty told me that in the early 1970s two researchers from a prominent university in New South Wales appeared at my uncle's home. They said they wanted to record and map cultural sites so Aboriginal customs would not be lost. Uncle didn't trust them because he didn't know them. They were strangers asking for information which was none of their business and he asked them to leave. The following day, the researchers came back with two muni-munis (policemen) who demanded uncle go with the researchers. He had to take them to cultural sites and tell them all the information they wanted to know. If he refused to go, the muni-munis would lock him up. Uncle had no choice but to go with the researchers. He gammoned (pretended) to take them to cultural sites and told them the biggest amount of bullshit. He was not paid a wage for the two weeks away from family, nor was any consideration given to how his family would cope without him. Having the privilege to work with researchers from a prominent Australian university was his payment. Uncle said all them whitefellas were interested in was that bit of

paper to prove they were experts in Aboriginal culture....they didn't care about the people (O'Donnell 2006b, pp. 156-6).

Unfortunately, opportunities for community control and/or capacity building through the two-way sharing of knowledge and power as described by the Yolngu people (Yunggirringa & Garnggulkpuy 2007) and Freire (1972), rarely occurred until recently. Strategies employed late last century such as development of Aboriginal health research ethics have helped to change this unhealthy dynamic (National Health and Medical Research Council 2003).

Aboriginal health research ethics

Over the last twenty years, due to the activism of Aboriginal Australians, Aboriginal research ethics have developed nationally following international trends of increased accountability and Indigenous rights in research. In 2003 an agreed framework for ethical considerations was developed between the Australian National Health and Medical Research Council, Aboriginal and Torres Strait Islander organisations, health services, researchers and community forums. This has led to an increase in collaborative research with Aboriginal and Islander people in all phases of the research process (National Health and Medical Research Council 2003). The framework is regarded as a guide for culturally safe and respectful research by South Australian Aboriginal health research organisations (Chong 2005a; O'Donnell 2006a). The framework outlines six core values of reciprocity, respect, equality, responsibility, survival and protection, spirit and integrity as shown in Figure 5.1 below.



(National Health and Medical Research Council 2003)

Figure 5.1 Aboriginal and Torres Strait Islander peoples values relevant to health research ethics

Aboriginal participants involved in the development of the framework stressed the importance of spirit and integrity as a central concept that binds the other values to each other. They also stressed the importance of understanding that the present and future are *absolutely bound up in the past and cannot be separated from each other* (National Health and Medical Research Council 2003, p. 9). These core values were used to guide our collaborative research. The Aboriginal Reference Group, co-researchers and stakeholders agreed that these core values also reflected local priorities.

Reciprocity

Reciprocity refers to mutual obligations, fair exchange, benefit for Aboriginal people and the inclusion of Aboriginal people in research as co-researchers. In this research I began respectful engagement through community consultations that enabled many people to share their opinions, priorities and concerns. The

purpose of these consultations was to ensure that it could meet local Aboriginal women's need for positive action. Aboriginal women were involved as co-researchers and mentors throughout the research process. Opportunities for capacity building and skills development were built into our collaborative activities such as ethics applications, co-planning, co-writing and co-presenting. We discussed the risks and benefits of the research, and had open discussions about how we could improve the research process and outcomes for all involved, particularly in instances of conflict, or potential conflict. Using Ganma and postcolonial feminism as guiding principles for my understanding of participatory action research enabled me to ensure that I respected and included all forms of knowledge as much as possible.

A commitment to reciprocity meant that co-researchers' needs were prioritised over the research process. For example, when working with community women, their priorities regarding a women's friendship group was addressed before interviews were suggested as interviews about 'urban Aboriginal women's health' was an abstract concept that did not meet their immediate needs. Another aspect of reciprocity involved reducing the burden of research on, and improving its applicability for the co-researchers. Where ever possible, our research was aligned with existing tasks, priorities and agendas. For example, Aboriginal Outreach Health Service co-researchers needed to evaluate their annual programs for statistical and reporting purposes, but had little time or resources to do so. Since part of the research involved seeking information about local services, we discussed the mutual benefit of my assisting them with their task, while in return they would indicate which data was appropriate for me to use for this research.

Respect

Respect refers to the need to take account of the dignity of people, accepting values, norms, knowledges and aspirations different to one's own (National Health and Medical Research Council 2003). Consent and any potentially negative effects were carefully discussed and negotiated. Co-researchers' contributions and knowledge were recognised and specifically named when they wish to be named (for example Elder's wisdom), and de-identified when they did not (for example employees discussing a controversial topic).

Researching in a small site such as Gilles Plains Community Campus created unique challenges regarding confidentiality of individual people. The use of themes rather than personal accounts enabled information to be shared and discussed in de-identified ways. Choosing postcolonial feminism and Ganma to guide this research enabled different perspectives to be discussed without suggesting blame or judgement. Throughout the study ethical issues were discussed regularly with my supervisors, both of whom have worked with Aboriginal people in Australia for many years. We aimed to place relationship building before formal academic processes. Any research activities were balanced by consideration of what was happening for the Aboriginal (and non-Aboriginal) co-researchers and their families and communities at the time. In times of high stress, grief and loss, research data gathering was suspended and support offered instead.

Equality

Aboriginal people continue to be marginalised from many aspects of mainstream Australian society through colonising, discriminating and Othering practices. Our research process promoted equity through the respectful sharing of knowledge and resources, and working in collaboration. Aboriginal women were involved in all research processes and decision making. Positioning Aboriginal community women central to this research was a strategy toward positively addressing and lessening (real or potential) power differences between community and health professional knowledge and experience.

Responsibility

During this research, the multiple responsibilities that many Aboriginal people and communities have to country, kinship bonds, caring for others and the maintenance of cultural and spiritual harmony and balance was respected. Aboriginal priorities and time lines have been recognised and the research process adapted to accommodate these. For example the timing of data collection and collaborative activities have been negotiated around community events, funerals, and child care responsibilities. Transparency about the purpose, methodology, conduct, potential activities, dissemination of results,

and potential outcomes/benefits of research has enabled Aboriginal people to make informed decisions about becoming involved with the research.

The Aboriginal Reference Group members, co-researchers and other participants guided all phases of this research. During the consultation process co-researchers and stakeholders discussed local politics and recent historical events that could easily be reignited leading to disharmony and conflict. As a result, considerable thought and discussion went into choosing methodology and methods that could maximise success and reduce potential harm. Ongoing formal and informal discussions and compilation of formal reports have been shared with the Aboriginal Women's Reference Group, co-researchers and stakeholders.

Survival and protection

Aboriginal people have identified the importance of protecting cultures, values and identities from further erosion by colonisation, marginalisation and poor research practices. Researchers need to recognise the strength and abilities of Aboriginal people, families and communities, and ensure that their research processes and outcomes respect and support cultural ties and bonds, not damage and erode them (National Health and Medical Research Council 2003).

Thus my aim has been to work with Aboriginal people in ways that enhance capacity, are supportive, and avoid research activities that could undermine the women, their families or community groups. Recognising that Aboriginal people are not a homogenous group, but rather diverse with their communities and individual experiences being as complex and varied as any other group of people, has also been important. Where ever possible Aboriginal women's strengths and achievements have been highlighted to counter the negative stereotypes portrayed locally, as well as within the media and wider society. For example, when working with the young Aboriginal women in school programs, positive Aboriginal role models were also involved, reinforcing positive opportunities and outcomes for Aboriginal women.

Spirit and Integrity

Many Aboriginal people¹⁶ regard spirit and integrity as the most important values that unite them. Spirit refers to the ongoing connection and continuity between past, current and future generations, and country. Integrity is about respectful and honourable behaviours that hold Aboriginal and Torres Strait Islander values and cultures together (National Health and Medical Research Council 2003). By using collaborative models and the holistic view of health, my approach to research has supported concepts and experiences of spirit and integrity. I was continually guided by the co-researchers as to what was important for them, and to remember that there could be important cultural, spiritual and personal aspects and preferences that I was unaware of.

User driven research & formal ethics application

Locating this research within a wider health and research agenda has been another important ethical aspect. Early meetings with Aboriginal health research leaders from the Aboriginal Health Council of South Australia (ACHSA) and Flinders Aboriginal Health Research Unit (FAHRU) and the Co-operative Research Centre for Aboriginal Health (CRCAH), has ensured that this research complements other existing research projects in South Australia as well as national directions of Aboriginal health research. A *facilitated developmental approach* to Aboriginal research promoted by the CRCAH, ensures that Aboriginal people and the Aboriginal health sector provide the priorities and directions for research, rather than external academics or researchers following their own interests (Brands 2005).

Preparing the ethics application was a collaborative process occurring after extensive consultation with Aboriginal community women, health professionals, the Aboriginal Health Council of South Australia (Chong, A. 2005, pers. comm., 23 June) and the Flinders Aboriginal Health Research Unit (O'Donnell 2006a). Formal ethics approval was sought and granted from the Flinders University Social and Behavioural Research Ethics Committee, the South Australian Aboriginal Health Research Ethics Committee, and Department of Education and Children's Services (see Appendix 2). Letters of

¹⁶ The NHMRC document discusses Aboriginal and Torres Strait Islander People. In this study I refer only to Aboriginal people, as no co-researchers identified as Torres Strait Islander people.

support were written by managers of the Gilles Plains Community Health Service, the Gilles Plains Aboriginal Outreach Health Service and Shine SA (see Appendix 3).

Informed consent and supportive paperwork

To ensure participant consent was voluntary and informed, a *Research Study Information Sheet* (Appendix 4) and *Letter of Introduction* (Appendix 5) were created and distributed. Those interested in being involved in the research were provided with an age appropriate *Consent Form* to be involved in interviews or focus groups (Appendix 6) and a list of *Trigger Questions* (Appendix 7), written in plain English. In addition, a list of de-briefing, counselling and referral pathways were provided (Appendix 8) in recognition that the research process may raise issues that may be distressing for some co-researchers and other participants.

Co-researchers were encouraged to take the form, read it, think about it and discuss it with family members, friends or colleagues if they chose. A specific form was developed to enable young people under sixteen, not living with care givers, to be involved, however none of the participants fitted into this criteria. Co-researchers were invited to attend interviews by themselves or with others, in a time and space of their preference. Similarly, consent from potential focus group members was discussed and all consent was given and the time and space negotiated.

Most participants asked to meet for interviews in the clinic room I used as a community health nurse at the Gilles Plains campus, reinforcing that my position as nurse/researcher was well accepted and trusted. I ensured that all participants understood that whether they were involved in the research or not had no impact on the health care I or my colleagues would provide for them. I offered all participants alternative health care providers. Some thanked me politely, said yes they understood, and then asked me to do their women's health checks. A hand out listing referral and counselling options was also produced, in recognition that discussing women's issues can raise distressing memories or issues.

Language

Terminology was changed to suit the local setting, and reflected health practice, academic and local speech preferences. For example, the Aboriginal community women named data collection, analysis and interpretation phases as *scheming*, and allocated specific times for this to occur. This clearly defined which conversations were to be included in the research, and which were to remain within the group. Similarly, using terminology such as Look and Listen, Think and Discuss and Take Action enabled the research to be understandable and accessible for a diverse group of people, regardless of their role, education, professional or research background.

Funding

To enable me to enhance reciprocity and reduce the risk to and/or burdens on participants, I obtained a Primary Health Care Bursary of \$2500 to enable the provision of catering, transport assistance, childcare and art supplies for women's health programs and focus groups. I also applied for and received an additional scholarship to enable Aboriginal women, as well as myself, to attend and co-present our findings at the 4th International Inequities in Health Conference held in Adelaide. This became a significant capacity building and research dissemination activity for both the Aboriginal community women and myself.

Aboriginal Women's Reference Group

As advised by the Aboriginal Health Council of South Australia, I invited key local Aboriginal women who had an interest in Aboriginal women's health to form an Aboriginal Reference Group to guide me throughout the entire research process. The group was made up of Elder women and other community women, Aboriginal researchers, health service coordinators and health professionals. I asked the Elder women how they felt about me, a non-Aboriginal woman, doing this research as part of a PhD, as I had heard that in some parts of Canada it is considered unethical for non-Aboriginal students to do so. They replied that they felt I had earned the right to do this research; I had worked with community for a long time, and they saw that my heart was in the right place. They were supportive of the research, hoped that I would

succeed, and get a job where I could have greater impact in improving Aboriginal women's health. This permission seeking was very important in a postcolonial context, as it reinforced the importance of Aboriginal Elders to be involved in decision making processes that affect their communities.

They had two stipulations. The first was that Aboriginal knowledge would be identified as such. They said;

We had this person come to us one evening and ask us how we deal with Aboriginal students. So we told her everything that we thought might help her. Next minute it is in the student paper that it was her idea to come up with those things, but it came from us (Elder women) and the Granny Group. A lot of information has been given to them but they take it as their own (Aboriginal Women's Reference Group 2005).

We agreed that people's knowledge would be identified in what ever form they chose, in conjunction with confidentiality preferences.

The other stipulation made specifically by Ngarrindjeri Elder women was that that they did not want 'the university' have sole control of the research process and outcomes, and the content and discussion of the final PhD thesis document. They explained that while they knew me, trusted me, and were comfortable co-owning the research process and outcomes with me, they did not have similar relationships with, or trust of, large government organisations such as the university. This stipulation was linked to previous experiences they had with government planning and legal systems regarding the Hindmarsh Island Bridge development on Ngarrindjeri land and water ways which led to their Traditional cultural knowledge, practices and preferences being publicly questioned, discounted and discredited. We made a decision that at least two of the Elder women would read the thesis before it was submitted and that any Traditionally sensitive data would be removed. After the final reading, they agreed that there was no culturally sensitive or gender specific information that

would prevent it from being housed within the university library and being read by a mixed gendered audience¹⁷.

Community consultations

Being a nurse/researcher who already had mutually respectful relationships with many of the Aboriginal people and other stakeholders enhanced the community consultation process, and enabled us to have deep discussions in relatively short periods of time. Prior to applying for ethics, I consulted with local Aboriginal community women, Aboriginal and non-Aboriginal staff and managers associated with the Gilles Plains Campus, and Aboriginal coordinators of state wide women's programs such as cervix screening, women's health and sexual and reproductive health. I asked the following questions 'if I was going to do research concerning Aboriginal women's health and primary health care, what do you think is important that I do and include? What would make this research meaningful? What would you like to see happen? What are the priorities?'

The *Elder women and co-ordinators of Aboriginal women's health programs* reinforced that:

The community has had enough of people coming in and doing surveys and research, and then nothing happens and they never hear of it again. We think you'd better work with the women and make sure that something actually happens spoken on behalf of the group by Ros Pierce.

Another said

If young Aboriginal women could feel respected, loved, accepted and worthwhile for one day, that would be a marvellous thing.

The *Aboriginal community women* 'connected' with the Gilles Plains Campus at the time (early 2005) were interested in research that *could help us get our women's group happening*. They were tired of talk, they wanted action.

¹⁷ As part of the PhD agreement, a copy of the thesis needs to go into the university library. Even though there is the capacity to place sensitive material in closed reserve area with restricted access, the Ngarrindjeri women preferred to ensure that no sensitive material was in it at all.

The *health and education professionals* in and around Gilles Plains, were cautiously supportive of research, as long as it did not create extra workload for (already overloaded) community health staff, or undermine any of the long term strategies to improve health care and relationships in the area. They felt the research should *work with and acknowledge what is already happening on the ground*.

Health managers expressed concern that social research could potentially inflame existing conflicts and/or reflect negatively on the health services. They agreed to support the research in principle, but would withdraw their support if it caused simmering conflicts to reignite (Community consultations 2005). I also consulted with a wider network of researchers and practitioners experienced in Aboriginal and primary health care research about appropriate methodologies and problem solving. Much relevant data was gathered during these community consultations. On the advice of the Flinders University Social and Behavioural Research Ethics Committee I included this information in my data after seeking permission from each person. If permission was not given, the files were deleted.

Basing the research at Gilles Plains

Through these consultations, analysis and subsequent discussion with my supervisors, the decision was made to base the research at the Gilles Plains campus where I worked as a community health nurse. The overall feedback was that there would be more value and reciprocity in me working with a smaller group of people, and doing meaningful work in one site, rather than doing pieces of work scattered across Adelaide or the state.

Supervisors and mentors

All four university supervisors who were involved in this research were knowledgeable about Aboriginal health, participatory action research and / or cultural safety. All were women, and all were supportive of enhancing Aboriginal women's health. Two Aboriginal professional women become mentors; Ros Pierce, Aboriginal health and Kim O Donnell, Aboriginal research.

Participant roles

Co-researcher refers to those directly involved in planning, discussing and effecting action. People who chose to actively participate included Aboriginal community women at Gilles Plains Community Campus ($n = 4$), staff members at the Gilles Plains Aboriginal Outreach Health Service ($n = 5$) and from the mainstream community health service ($n = 3$), staff at the nearby high school ($n = 5$) and co planners of an action research and action learning conference ($n = 10$). Each co-researcher chose for themselves the level of participation they wished to make. Detailed descriptions of co-researchers are not given as this would identify them as individuals in this small health care and research setting.

Stakeholders were those who affected or were affected by the research but were not directly involved, and includes Aboriginal Elder and community women ($n = 7$)¹⁸, young Aboriginal women ($n = 10$) Aboriginal mentors ($n = 2$), university supervisors ($n = 4$), staff from ethics committees ($n = 4$), Aboriginal health co-ordinators ($n = 4$) and managers ($n = 4$). Many were involved in the community consultations, played a peripheral role in planning and actions, and were involved in discussions involving emerging themes. They were less involved in the actual 'hands on' activity, but were recognised as having an opinion or influence on what could, should or would happen.

Nurse/researcher/facilitator describes my role in this research, highlighting the combination of nursing, research and community development.

Participatory action research (PAR)

Overall there was a preference for research that enabled both Aboriginal community women and health professionals to participate directly, with other stakeholders having indirect input. The research needed to be culturally and personally safe, easily understood by a wide range of people with differing educational, cultural and research backgrounds, adaptable and flexible. It needed to be responsive to, and inclusive of, a diverse range of participants' priorities and knowledges, and lead to collaborative action and win- win

¹⁸ And potentially at least twenty more Aboriginal women who accessed local services and our women's health days.

situations. Increasingly, research in nursing, health promotion and early education add strength to the notion of new ways of working together *with* Aboriginal people in strength based, collaborative, and knowledge sharing ways (see for example Puzan2003, Brough, Bond & Hunt 2004 and Power 2004). Co-researchers and I also envisioned a methodology that could help us create new knowledge together *and* put it into practice. These criteria led us to action research.

I had a strong interest in finding ways of collaboratively. In my previous Masters research I had attempted a basic participatory action research, but while knowledge sharing had been shared *within* each focus group of like minded people, I had not developed a strategy for sharing and building knowledge and action *between* the different focus groups. In this research project, finding ways of sharing knowledge and working together toward pragmatic and positive outcomes was crucial. The Ganma knowledge sharing metaphor suggested a way forward, and I was keen to find a methodology that would assist us to put this into action. Reflecting on the community consultations and Aboriginal Women's Reference Group discussions, many other people shared this aim.

There are many forms of action research, each with its own underlying history and philosophy (Reason, Peter & Bradbury, Hilary 2006). What they have in common is that they have both a research **and** an action component. Most have an emergent methodology ('growing' the way of doing research as the research unfolds and deepens) that aims to achieve change (action) and understanding (research) at the same time (Dick 2007). The research process is usually cyclical, participative and qualitative with earlier cycles informing later cycles. Methods, data collection, analysis, interpretation and future action develop through and by each cycle. Knowing and doing are intertwined (Stringer 2007). Often multiple methods and triangulation (using multiple methods and theories to draw conclusions to prevent a bias) are used to collect and analyse data, increasing rigour and credibility (Grbich 2004).

There is a great variation in the extent of collaboration and participation within different forms of action research. Hart and Bond (1995) describe these differences by identifying the role of researchers and participants.

Experimental and organisational forms of action research place researchers as outside experts, coming in to work with others to meet pre-determined (often top down and management driven) aims. In comparison, *professionalising and reflective practice* forms of action research place the researcher as a collaborator working alongside practitioners toward the empowerment of professional groups and as an advocate on behalf of clients. *Empowering/ consciousness raising* action research places the practitioner/researcher as a co-researcher working with groups in a bottom up process that involves shifting the balance of power and negotiating outcomes (Hart & Bond 1995). In this study we incorporated and extended the last two forms of action research into what is often described in the literature as Participatory Action Research or PAR. These concepts complement critical theory and feminist paradigms and enable democratic Ganma knowledge sharing relationships to develop.

Participatory Action Research or PAR has two objectives. The first is to produce knowledge and action directly useful to a group of people, and the second is to enable the self empowerment of people at a deeper level through the construction and use of their own knowledge (Reason et al 2006). Over many years, PAR has been built on concepts of collaboration, adult learning and self empowerment. It involves two-way, democratic learning and adult education that leads to personal empowerment as described by Freire (1972) and Belenky and colleagues (Belenky et al. 1973). The feminist movement has assisted PAR researchers to consider how issues of gender, race and domination impact on consciousness raising and life opportunities (Maguire 2006; Moreton Robinson 2002; Reason et al 2006). Post colonial and decolonisation theories have encouraged researchers to recognise and address inequality linked to discrimination, colonisation practices and the domination of Western knowledge (Browne et al 2005; Smith 2003). Indigenous methodologies such as Ganma have further encouraged researchers to value, respect, and ensure that more than one form of knowledge can come together to legitimately create new knowledge (foam) (Gullingingpuy 2007; Hughes 2000).

In the international action research literature, there is renewed recognition of participatory action research as an appropriate and culturally safe methodology

in this new millennium. Reason and Bradbury (2006, p. 1) describe action research as:

A participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory world view which we believe is emerging at this historical moment. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people....and their communities.

Aboriginal health research ethics highlighted the need for research that supports more meaningful participation of groups who were previously ‘the researched’ (National Health and Medical Research Council 2003). Participatory action research as described by Reason and Bradbury encourages researchers to be decolonising in intent and nature. Co-researchers and I discussed a range of approaches and chose Community Based Action Research with repeated cycles as described by Stringer (2007) as being the most appropriate. Stringer proposes three phases of Look (data gathering), Think (interpreting and analysis) and Act (resolving problems – planning and implementing sustainable solutions)

Building the picture – Look phase

During the initial *Look* data gathering phase, research participants are encouraged to describe their situation clearly and comprehensively (Stringer 2007). This allows taken for granted visions, beliefs and viewpoints, and individual perceptions of reality to be brought out into the open to be examined, adjusted and or transformed in a process of liberation and enlightenment similar to that described by Freire (1972). A wide range of methods or tools are used including interviews, focus groups and meetings, literature review, mapping exercises, and joint analysis.

Interpreting and analysis – Think phase

During the second interpretive and analysis *Think* phase, research participants are encouraged to interpret and analyse the issues they are addressing. Interpretation involves clarifying meaning in order to make better sense of

one's experiences. Stringer (2007) advocates concepts drawn from people's day to day lives and personal epiphanies¹⁹. As participants clarify the meaning of events, they come to understand the conceptual structures and pragmatic working theories of themselves and others. The complex chaos of situations becomes apparent. Stringer (2007) describes four different approaches to interpretation including; using interpretive questions of why, what, how, who, where and when; organisational review; concept mapping and problem analysis. We used all four at different times. In their book *Action Research in Health*, Stringer and Genat (2004) highlight that in action research, the emphasis is on investigation driven by participant perspectives rather than those contained in the literature. Data analysis becomes an interactive process between stakeholders through shared accounts and joint accounts.

Resolving problems - Action phase

The third phase involves resolving the problems through planning, implementing and evaluating action. Stringer (2007) advocates that planning for action should involve all stakeholder groups to prevent future problems, disengagement and/or sabotage. All participants review the issues and formulate priorities. Goal setting using why, what, how, who, where and when questions become a collaborative process that identifies priorities and how everyone's needs can be met. Implementing the plan involves collaborative community based processes supported by the research facilitator who may assist with communication, reflection and analysis, linking people and resources together, conflict resolution and nurturing people as they try new roles. Regular review is important to monitor progress (Stringer 2007).

More complex situations require additional strategies. A unifying vision is developed by strategic planning, and then enacted through agreed operational statements and creating action plans that define objectives, tasks, steps, the people to be involved, places, timelines and resources. Plans are reviewed in view of opportunities and threats, financial considerations, resources available and organisational and community arrangements. Democratic and collaborative involvement, decision making and evaluation can be challenging to maintain

¹⁹ Epiphanies are personal turning points, moments of clarity, 'ah ha' or 'light bulb' moments, a moment in time when something suddenly becomes clear.

when working with top down hierarchies, but is a crucial element of community based action research (Stringer 2007).

Evaluation is undertaken by participants to monitor progress. Evaluation is not made by external evaluations in order to *make judgements about the worth, effectiveness, success or failure of a project* (Stringer 2007, p. 160); rather the emphasis is on participant learning. If external formal evaluations are required, participants are supported to co evaluate to meet requirements. Celebrating success is recognised as an important way to increase feelings of positiveness, well-being, competence and recharging energy, and to reflect on what it is possible to accomplish together.

Stringer explains that as the research process deepens, the initial phases of Look, Think, and Act are repeated and evolve into cycles of *looking again (reviewing), reflecting (reanalysing) and modifying actions (re-acting) occur* (Stringer 2007, p. 9). However, he also advises that in practice, participants and research/facilitators usually can not carry out research in such neat, orderly cycles; rather there are moments of going backwards, repeating cycles, leaping ahead, or making changes as they go along. This emergent, flexible and responsive methodology appealed to us as being realistic and appropriate for our local situation.

Stringer also discusses the dilemmas faced by action researchers to meet academic requirements while honouring the people they have worked with collaboratively. He identifies that *formal reports often silence the voices of those of whom they speak* (Stringer 1999, p. 168). In order to change this, action researchers often use narrative accounts (people's stories) and focus on participants' perspectives, and then contextualise these within the broader social context by comparing and contrasting their accounts with existing academic, institutional and organisational interpretations of the issues. The implications of the study for policies, program and practices are then discussed, highlighting what the research means in the broader context.

Adapting PAR to meet our needs

In this collaborative research underpinned by Ganma knowledge sharing, it was important that co-researchers and I combined the external (salt water)

PAR process with our own (fresh water) priorities, concerns and knowledges, to create a collaborative method that could work well in our own situation (foam)²⁰. In conversation local Aboriginal community women and health professionals discussed their concern about not being heard, and we renamed the first phase to be *Look and Listen*. This reinforces the concepts within Dadirri and Cultural Permeability that if people look without listening, misunderstandings occur. Co-researchers then stressed the importance of discussion as well as thinking to prevent assumptions being made. We renamed the second phase *Think and Discuss* to emphasise the importance of collective decision making. Regarding the third phase, we renamed Act to become *Take Action*, to give it a more energetic focus.

A pictorial and table form of our collaborative PAR model is shown on the next two pages, suiting the needs of different people's knowledge sharing styles.

²⁰ This is a slight variation of the original Ganma knowledge sharing – we used the concept in a variety of ways.

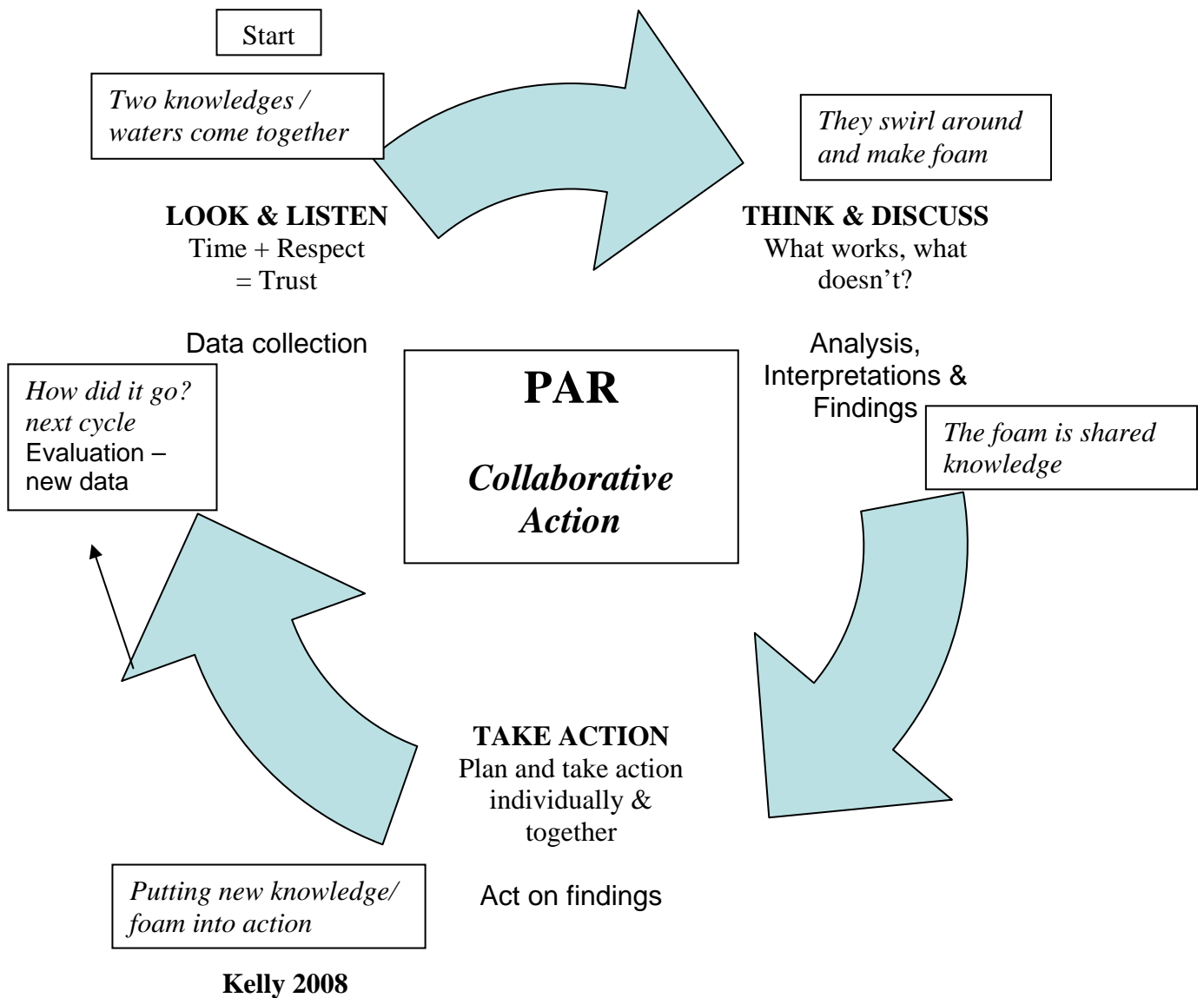


Figure 5.2 Our PAR knowledge sharing model

Table 3.1 An overview of our collaborative PAR model

| PAR phases | Ganma | Activities | Methods | Questions |
|---|--|--|--|---|
| Look & Listen <i>Awareness of differences & similarities</i> | Two waters come together, saltwater and freshwater | Gathering data | Community consultations Literature review Interviews, meetings & focus groups – semi structured | What is happening? |
| Think & Discuss <i>Work through assumptions work with our similarities & differences</i> | They swirl around together and make foam/new knowledge | Interpretation Analysis (themes) Negotiation | Collaborative interpretation & thematic analysis during interviews and focus groups My additional analysis, reflective journal and coding using QSR Nvivo 7 | What does it mean for us? What are the findings |
| Take Action <i>Using the resources we already have / can get access to</i> | This foam/new knowledge is then used collaboratively | Individual & collective action | Collaborative action planning & implementation. Health days, co-presentation, conferences, mapping, program provision | What will we do about it? What are the findings? |

As the research continued and we trialled our model, discussed and reflected on it, we realised that we had created a model of collaborative practice suitable for working in a range of settings.

Implementing PAR – our use of methods

In order to implement our version of PAR, a range of methods and tools were needed. Interviews focus groups, literature review and document analyses were methods used to collect data. Analyses occurred collaboratively and

individually. Collaborative thematic analysis began with co-researchers during semi structured interviews and focus groups as they interpreted and clarified their responses to trigger questions. I conducted additional analysis using QSR NVivo 7 computer software and an electronic and hand written reflective journal (which enabled me to draw pictures more easily). All emergent themes were taken back to co-researchers for further consideration and incorporation into planning and action phases. Collaborative action involved pooling resources, skills and abilities and working together to put ideas into action. Reflections on our action informed the next cycle of look and listen again (evaluation), think and discuss and take action. Themes were gathered together, compared and contrasted to create findings.

Literature review, oral knowledge and document analysis

A literature review was conducted throughout this research, searching for literature that both supported and challenged what was being discussed in interviews and focus groups. Reviewing government, health policy and organisational documents enabled a stronger picture of health system and organisational priorities and culture to be built, which we then compared with what was happening around us.

The literature review evolved in four stages

During the first stage I read widely and spoke with many Aboriginal community members and health, education, academic and research professionals. In recognition that much Aboriginal and practice knowledge is oral rather than written, I considered community consultations and personal conversations as literature, as well as texts, refereed articles, conference presentations, project reports, government documents and policy documents. I critically reviewed all of this information, further refining my research questions and identifying gaps in knowledge and literature. This early literature review informed the ethics process, just as ethical considerations informed the way the literature review evolved.

The second stage developed alongside data collection and analysis activities. As new themes arose I checked that the literature I had gathered was still relevant and sought new literature. For example, early in the research I began

to suspect that the concepts of colonisation and collaboration would be important to include and had a small section prepared. After speaking to a range of participants, it became obvious that colonisation was incredibly significant, but not well understood by non-Aboriginal people. This led me to increase my reading and writing in this area significantly, and devote a whole chapter to the topic. As the data was analysed, we identified the dominance of Western/English/professional knowledge and one way communication in Australian society and health care systems and the negative effects these have had on Aboriginal women's health and well-being. My search for literature that could assist me to understand and explain this in more detail led me to postcolonial and feminist literature.

Postcolonial feminism led me to actively seek Indigenous viewpoints and question colonising assumptions within literature. Choosing appropriate texts, particularly those related to early colonial activities, has been challenging because each text reflected the underlying beliefs of the author and society at the time that it was written (Said 1993). In discussion with co-researchers, advisors and supervisors, I devised a hierarchy of references that recognised the work of Aboriginal researchers, non-Aboriginal researchers who research and publish with Aboriginal people, and then others. Even with this strategy, there have been difficulties in presenting information in a way that is acceptable for diverse Aboriginal and non-Aboriginal co-researchers. Understandably it is not always possible to gain consensus about what is a 'reasonable account' of a cultural issue or historical event. However, I have taken this approach in recognition that not to foreground Aboriginal voices continues the colonising process.

I have attempted to write this thesis in a way that highlights multiple perspectives and alternate experiences while still being respectful of Aboriginal Traditional culture. I have tried to avoid referring to Aboriginal groups of people as if they were one homogenous²¹ group, but at times have made some pragmatic generalisations, particularly when discussing South Australian colonial history and health care trends.

²¹ Homogenous refers to all being the same

The fourth stage involved the co-researchers reading sections of this thesis and commenting on choice of literature. This has been a purposeful ethical and moral step toward sharing the power inherent in being a non-Indigenous author of this Indigenous focused PhD thesis, and ensuring that the process of representing Aboriginal and non-Aboriginal co-researcher viewpoints is as collaborative and equitable as possible. Where changes were suggested, we discussed these and came to an agreement about acceptable language and phrasing.

Semi structured interviews with trigger questions

Semi structured interviews were guided by trigger questions as suggested by the Aboriginal Health Council of SA (Chong 2005b). **Trigger questions** were developed initially through the community consultations and then revised as new themes as these emerged through the PAR cycles. Co-researchers chose whether they wished to be involved in interviews or focus groups, and if so where and when they would prefer to meet, and whether or not they would like it audio taped or for me to take notes. On each occasion I transcribed the interview or focus group and returned the transcript to the participant/s for corrections, changes or additional comment, following concepts of member checking as described by Stringer (2007). Often discussions developed before and after formal meeting time and these were included in the data if the person gave permission. If literacy was a consideration, I read the transcript with the co-researcher and we made changes together. It was agreed that any changes a person wished to make would be honoured, and that the deleted information would also be removed from my data base. This ensured that co-researchers had control over what information they chose to share, both immediately and on reflection. Considering the conflicts and negative experiences of research and institutions that existed for many co-researchers (Aboriginal and non-Aboriginal alike), this was a very important consideration.

Fifteen semi-structured interviews took place, with each lasting between thirty minutes and one and a half hours. The average was an hour. Interviews were recognised as involving both knowledge sharing and personal capacity building. Prior to an interview, many co-researchers expressed a concern that they had very little to contribute, only to discover that they actually had much

to contribute. The existence and extent of their own knowledge was reinforced when they received a typed transcript of their interview. Most women reflected that they now had a greater understanding of their own knowledge, developed through explaining their viewpoints in the interview. In ways similar to Belenky, Clinchy, Goldberger and Tarule's (1973) *Midwife and Connected teaching*, co-researchers were encouraged and supported to work through moments of uncertainty, to bring their ideas into maturity. At a follow up meeting time (which occasionally developed into a second interview), co-researchers reflected on their transcripts and chose in what style they would like their knowledge shared with others; in de-identified themes or stories.

Focus groups

Focus groups occurred in a range of settings, unique to each group and Collaboration Area. Focus meetings involving Aboriginal Elder women were held in one of the women's homes and included lunch and transport assistance as a sign of respect and reciprocity. Focus groups with local Aboriginal community women at Gilles Plains occurred in community health buildings. Those involving health staff occurred in health buildings or outside in the garden. Focus groups involving school staff and students usually occurred in the teacher/counsellor's room at the high school. Focus groups involving Team SA members planning a conference occurred in private homes, the Aboriginal Health Council of South Australia and Tauondi College, an Aboriginal adult education centre.

Meetings and discussions

Data was also collected during meetings and informal discussions. Meetings included staff planning meetings and campus meetings. Discussions were face to face, telephone or email conversations regarding the research. Permission was always sought to include this information in the research.

Managing data and transcripts

Raw data recorded on butcher's paper and audio tapes were transported securely in a locked brief case and stored in a locked filing cabinet. All electronic information was stored on my personal lap top and kept in a secure

location. The names of research participants were stored separately to the data, transcripts and thesis, and coding was used when entering data onto the NVivo computer software.

Coding for analysis

In order to include women co-researchers and stakeholders voices and viewpoints, but not identify them as individuals (which is what many specifically asked me to do), I devised a coding system specific to each Collaboration Area. For example, in Collaboration Area one, AWG D refers to discussions with a small group of four Aboriginal community women. WFG refers to discussions of the Women's Friendship Group made up of both Aboriginal women co-researchers and other interested Aboriginal and non-Aboriginal women. AOHS indicates Aboriginal health service. D refers to discussions, I interviews and FG focus group.

Trustworthiness, accountability and rigour

Trustworthiness of this research is linked to close relationships with co-researchers, stakeholders and mentors and their involvement in all stages of this research, including the review of their own transcripts, the emerging themes, research findings, and the final document. The research process was open and transparent, with my personal nurse/researcher agenda and motivation clearly explained. At all times I remained accountable to the Aboriginal women and community, the health services, university and research body. Ethical considerations were considered paramount and addressed to the highest level possible. Rigour refers to following recognised research practices of collecting, tracking, analysing and storing data in ways that are recognised as valid.

Analysis and interpretation

Co-researcher and stakeholders' analysis and interpretations occurred as they began to make sense of their own day to day experiences in discussions, interviews, focus groups and meetings. Analysis is the process of investigating, exploring, probing, reviewing and evaluating what has been said, heard or experienced (Stringer 2007). We used six questions of 'who, what, how, when,

where and why' to explore the multilayered and complex nature of Aboriginal women's health and well-being and health care. Both individual and group themes emerged (thematic analysis), and were then shared with other co-researchers, enabling a wider, multi layered analysis to occur. These themes informed the next action phase, and came together to create findings. Retrospective discussion one year later added another layer as co-researchers reflected on what it all meant, what was achieved and what changed.

Co-researcher and *stakeholder* analysis is presented in thesis text as personal accounts (quotes from interviews and focus groups) and emerging themes. These appear in text (usually in the think and discuss phase) where they occurred. This enables the women's discussions and actions to remain in context, rather than taken out of context. Co-researchers and mentors strongly stressed the importance of not taking Aboriginal women's knowledge and decisions out of context.

Alongside, and interwoven into co-researchers' analyses is *my own interpretation and analyses* generated from my unique nurse/researcher/facilitator perspective. Throughout the research process I analysed data gathered from interviews, discussions, focus groups, meetings, document and literature review, using my nursing knowledge, Aboriginal health research ethics, postcolonial feminism and my contribution to the Ganma two-way knowledge sharing, and the principles of primary health care and cultural safety as my guide. In some cases I report on the women's knowledge or the way in which we created Ganma knowledge.

Critical Reflection Journal

I kept both an electronic and paper reflective journal, enabling me to track and reflect on what I saw, heard and read, and begin to identify possible themes across Collaboration Areas. Use of a *practitioner/researcher critical analysis tool* (see Appendix 9) encouraged me to recognise various aspects of my own (salt water) knowledge, and how these impacted with co-researchers' (fresh water) knowledge. Stringer discusses the importance of bracketing, holding in abeyance our own professional stock of knowledge in order to allow co-researchers time and space to explore and describe issues in their own terms

(Stringer 2007, p. 70). Using the reflective journal helped me keep track of my own emerging ideas, without influencing the data collection process. During the analysis Think and Discuss phase, I shared my analysis and interpretation, seeking responses from co-researchers, which I then analysed again.

Using computer software - coding and themes

In addition, I entered all of the transcripts and reflective journal onto my laptop (in de-identified form) and used an NVivo program to code and compare data. This enabled me to identify and track themes, trends and contrasts across the entire project. I discussed these with co-researchers, to see if my interpretation and theirs were similar or different (verification), and what this might mean. For example, while coding transcripts I determined that most co-researchers spoke about the past and ongoing impact of colonisation. When I discussed this further with co-researchers they identified that it was an issue that affected Aboriginal women's lives daily. As a result of this, I read more deeply about colonisation, post-colonial theory and decolonisation strategies.

in text in this thesis

My analysis appears in three places in this thesis. Firstly in the think and discuss phase alongside co-researcher analysis where my nurse/researcher/facilitator knowledge intermingles with co researcher's in Ganma two-way knowledge sharing. For example, my contribution in identifying the differences between comprehensive and selective primary health care led to a particular theme reflecting these differences. My involvement at these times is clearly indicated in text.

The second place my analysis appears is at the end of each Collaboration Area chapter under the headings of *knowledge sharing*, *working together* and *taking action*, where I had analyse the process and themes from my own critical postcolonial feminist nursing perspective. This analysis is considered to something that sits *alongside* not *over* co-researcher analysis.

The third analysis in the final discussion and findings chapter brings together themes from across the entire research, compares and contrasts them, and identifies findings. The significance of the overall research process and

findings are then considered within the wider context of health care and Aboriginal women's health and well-being.

Story telling

Story telling was used in data collection and analysis, and in discussing results and interpretation of the findings. Story telling enables the women's knowledges, experiences and actions to be shared in their own words and/ or in context of what was happening for them at the time, as described by Koch, Kralik, van Loon, and Mann (2006). In this study, many Aboriginal co-researchers and mentors stressed the importance of taking the time and effort to respectfully tell, hear and share the whole story in context rather than taking actions and meanings out of context, as that leads to misunderstanding, assumptions and judgements. For example, in the first Collaboration Area chapter, the Aboriginal community women's stories and experiences are told from their perspective, before the PAR process is discussed. This foregrounds their understanding and experiences.

Negotiated writing style for our collaborative research

Following concepts of Ganma knowledge sharing I endeavored to combine our (freshwater) collaborative research knowledge and experiences, with (saltwater) academic research writing styles, to produce an account (foam) of our research that is meaningful for diverse co-researchers, stakeholders and examiners. While many people advised me to write two documents, one a community report and the other a thesis, this option was unacceptable for many of the co-researchers and Elder women. They said *if you write it in academic ways, how can we still read it and approve of it*. In the interests of ethical research, Ganma two-way knowledge sharing, and challenging the status quo of power dynamics as encouraged by postcolonial feminism, I therefore endeavored to write the one document that combined different ways of knowing and understanding together.

Following data gathering and analysis, co-researchers were supported to plan for action based on the themes and priorities that they had identified in the think and discuss phase. Recognising that *one size fits all* solutions based on external assumptions rarely meet local needs, co-researchers were supported to

work collaboratively to develop appropriate plans for action.(Calma 2007; National Health and Medical Research Council 2003; Wadsworth 1998). We began by brainstorming ideas to broaden our thinking, and ensure everyone's ideas were heard and recorded (often on butcher's paper or the whiteboard). The six prompt questions of who, what, where, why, how and when were again used to cover all aspects. We then prioritised which of these we (collectively) wished to address, considering potential benefits and consequences, the resources available, and whether there were any personal or professional risks or costs involved. Sometimes it was appropriate for one or two people to pursue one of the lower priority strategies themselves.

Written action plans recorded what we had discussed and who would do specific tasks. These action plans became flexible documents that adapted to changing events and situations. Whenever possible the writing of these plans was shared to increase collaborative ownership and capacity building. Action was an integral part of this research, rather than a possible addition. Co-researchers enacted their plans in response to the themes and findings. Actions varied enormously from group to group depending on their own priorities. They included creating a women's group, holding women's health days, networking between services, co-presenting findings, promoting effective communication, and hosting a national action research/action learning conference.

The emergence of four unique yet interconnected areas of collaboration

Community based action research is by nature, largely unpredictable. Co-researchers begin with a basic idea that develops and changes in dynamic ways (Stringer 2007). This research project began with questions about how collaboration might improve Aboriginal women's health and well-being, and evolved into four different areas of interest that we chose to call Collaboration Areas²². Each Collaboration Area involved a specific group of people based at or near Gilles Plains Community Campus, and discusses how they identified and addressed the priorities concerning Aboriginal women's health and well-

²² In many ways these are like case studies, but most Aboriginal co-researchers disliked the term case study due to its connotations with negative colonisation practices in health care and research. Our Collaboration Areas have specific emphasis on democratic collaboration and power sharing.

being using our collaborative PAR process. These Collaboration Areas are both independent from, and connected to, each other.

The first Collaboration Area involved a small group of local Aboriginal community women and their priorities for women's health and well-being. The second involved health professionals at the campus grappling with the complexities and realities of trying to provide comprehensive primary health care services for Aboriginal women and their families. The third involved improving access and services for young Aboriginal women, and the fourth Collaboration Area discussed how we developed a national action research / action learning conference as a result of our experiences and findings in the first three Collaboration Areas. These four Collaboration Areas intertwine together and are shown in a table format at the end of this section.

Collaboration Area 1- Local Aboriginal community women's priorities

Once the decision was made to base the research at the Gilles Plains Community Campus, I began talking with Aboriginal community women still connected to the Gilles Plains Community Campus, and invited them to become involved in the research as co-researchers. This small group of Aboriginal women were already known to me through my community health nursing practice and they asked me for assistance in '*getting their needs met amongst health service changes*'.

Collaboration Area 2 - The emerging Aboriginal health service

I also invited health staff at the newly developing Aboriginal Outreach Health Service and mainstream community health service on the campus to be involved as co-researchers. These health professionals identified the challenges and practicalities of trying to provide comprehensive primary health care for Aboriginal women and their families within a constantly changing and redeveloping health service. Many staff members felt unable to meet local community needs with the limited resources available to them, and frequent changes in staff, management, organisation and policy. Together we identified challenges, possible resources and strategies, and planned events to meet local women's needs. They stressed the importance of collaborative action that complemented rather than complicated their existing programs and work loads.

These first two Collaboration Areas are discussed separately and in relation to each other, highlighting the complexities, changes and multiple perspectives and expectations of health care delivery and its ability to meet diverse Aboriginal women's health and well-being needs. Rather than suggesting one group is 'right', and another 'wrong', postcolonial feminism (Browne et al 2005; McConaghy 2000) assists with the exploration of ways that gender, class, employment status, socio-economic status, cultural aspects, professional positioning and power differences intersect with and reflect colonisation, creating both shared and unique experiences in post-colonial Adelaide.

Collaboration Area 3 - The high school and the health service

The third Collaboration Area involved improving networks, communication and education between the local high school and the Aboriginal Outreach Health Service. Very few young Aboriginal women were accessing services at the campus, except for medical treatment and pregnancy care in mid to late pregnancy. Both the school and the health service were keen to work together to improve young Aboriginal women's access to health information and services.

Collaboration Area 4 - The decolonising conference

The fourth Collaboration Area developed as co-researchers, stakeholders, mentors and I identified the need for deeper and wider discussions regarding knowledge sharing and collaborative action in the research context. A national action learning/ action research conference, underpinned by Aboriginal preferred ways of knowing and doing, was planned and implemented. This collaborative action ensured that our research processes, outcomes and learning were able to be shared in ways that honoured Aboriginal intellectual property, reciprocity and Ganma processes of respectful two-way knowledge exchange.

These four unique yet interwoven Collaboration Areas have enabled co-researchers and myself to envision, develop and 'road test' our collaborative PAR methodology in a range of situations. Comparing and contrasting the themes arising through each Collaboration Area enables this research to be inclusive of a range of knowledges and perspectives, while still honouring individual knowledge. A chart outlining and comparing all four Collaboration

Areas is available in 11. Importantly, from a post colonial feminist perspective, the use of Collaboration Areas has enabled me to work with diverse co-researchers without labelling one group as right, and another as wrong.

3.2 A Table Outlining and Comparing all Four Collaboration Areas

The table below gives an overview of the four Collaboration Areas in an easy reference format.

| Collaboration Areas | 1 Local community priorities | 2 The Aboriginal service- vision Vs reality | 3 The high school and the health service | 4 A national action research/action learning conference. |
|----------------------------|--|---|---|---|
| Collaboration focus | Collaboration with community members | Collaboration within a health organisation | Collaboration between sectors | Wider collaboration |
| Co-researchers | Local Aboriginal community women | Staff at Gilles Plains Community Health and Aboriginal Health Services | Staff at high school | Team SA – a dynamic group of people who came together to create a conference |
| Stakeholders | Families and communities Health staff and management Aboriginal Women's Reference group | Young Aboriginal women Health & education staff & managers Elder & community women | Managers of health and education services, Community members Elder women | Community members, researchers, professionals, managers, policy makers, academics, politicians etc |
| Co-researcher priorities | Stress & healing Relationship building Women's group Access to comprehensive primary health services | The practicalities of providing health services High need, not enough resources High turn over of staff Practical action | Young Aboriginal women's access to culturally safe education, health information and services | Creating spaces where Aboriginal and non- Aboriginal people could discuss collaborative practice in education, health & environment. |
| Actions Taken included | Women's friendship group Co-writing & co-presenting Negotiation with services | Concept mapping Networking Women's health days | Women's health days Leadership program Dance , school expo | Planning and implementing a national AR/AL conference |

Summary

This chapter has discussed the ethics and methods collaboratively chosen and used in this research. Aboriginal health research ethics were used to guide this research to be culturally safe and respectful of two-way knowledge sharing in postcolonial Australia. A participatory action research approach was co-created to ensure that co-researchers could be involved in all aspects of the research, in which ever ways they chose. A range of methods were used in repeated phases of Look and Listen, Think and Discuss and Take Action. Themes that arose in each cycle informed and triggered action within each Collaboration Area. Overall findings were then considered within the wider context of health care and Aboriginal women's health and well-being. The relationships between the repeated cycles of Look and Listen, Think and Discuss and Take Action that we developed, to the three central themes of knowledge sharing, working together and addressing issues are shown visually in Figure 5.3 below.

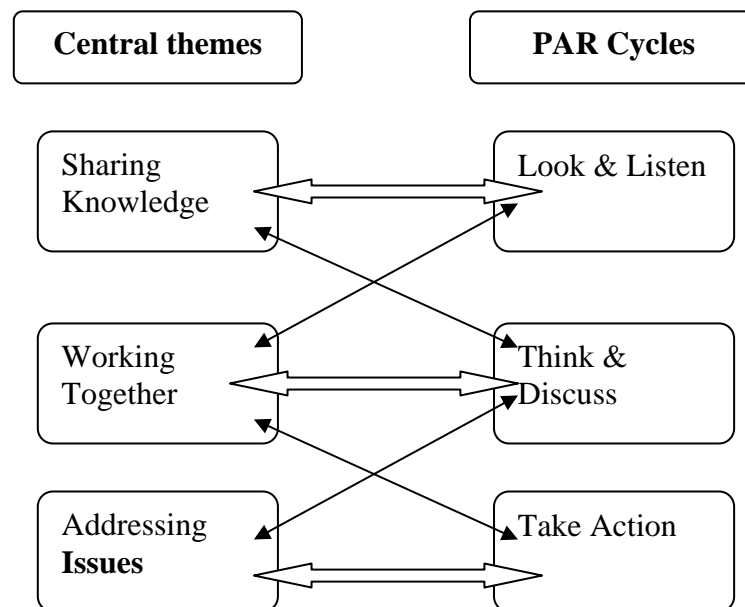


Figure 5.3 The correlation between the PAR cycles and central themes

As can be seen, these do not fit neatly, but overlap, with different themes relating to different aspects of the PAR cycles. This reflects the way that the

research process needed to be flexible in order to meet the complexities and changing research environment.

In the next chapter I introduce the community health site where much of our collaborative research took place. The first three Collaboration Areas were focused around the Gilles Plains Community Campus and involved Aboriginal community women, Aboriginal and non-Aboriginal health professionals and the nearby high school students and education professionals.

Chapter 6 The Specific Research Context

This chapter describes the site where three of the four research projects took place. Basing the research at one site has enabled a deeper exploration of the complexities of health services development and Aboriginal women's access to emerge. Two specific aspects were highlighted during this research. The first involved the end effect of policy, program and organisational changes, and second involved the ways that this impacted on (and was impacted by) relationships between Aboriginal community women and health professionals. In order to explore these aspects from a range of perspectives, a mixture of health service documents, community consultations with health professionals and Aboriginal community members, and my observations as a co-located community health nurse and researcher are used. In recognition that one needs to understand the past in order to understand the dynamics of what is happening now, a history of the Gilles Plains Community Campus, highlighting the policy and health systems changes and factors that have impacted on local community participation, community development and comprehensive primary health care provision, is discussed.

The suburban Gilles Plains Community Campus is a multi agency health and education site located in the North Eastern suburbs of Adelaide, South Australia. It provides community primary health care services (both mainstream and Aboriginal specific), community assistance, childcare, primary and preschool education. Many different services and agencies are co-located in older and newer primary school buildings across the campus which is owned by the state Education Department.

Health provision at Gilles Plains – a historical overview

Pre-colonisation, the Gilles Plains area was a wide valley with a central river, open woodlands and water holes, being country of the Kaurna people. With colonisation, Western settlers began moving out from the central city area along the river and used the area for cattle grazing and then chaff production, changing the landscape and claiming the land as their own. It was used for farming for many years until the 1930s Great Depression when it became bare

and weed covered. With the 1950s population increase and European migrant immigration, housing in the area boomed with many families with young children moving to the outer suburbs. The Gilles Plains Primary School expanded and grew to meet the needs of these families.

In 1980 the North East Community Assistance Project (NECAP) was formed by local residents at the Gilles Plains primary school campus in the original brick school building. Funds generated through the NECAP volunteer thrift shop were used to assist people in need by providing food and household goods at no cost (Stark & Coulls 2007). Changing demographics in the area led to school population reducing, leaving more of the older school buildings empty. Most of the surrounding residential area was populated by lower socio economic public housing tenants but there were few health, welfare and related community services lacking in the area. Staff from a variety of public human service agencies came together in 1981 and the Gilles Plains Neighbourhood Centre was developed in the old wooden school buildings as an experimental project (Stark & Coulls 2007). The Gilles Plains Community Campus began through community development and responsiveness to local needs. This set in place very specific community expectations about their level of involvement, engagement and decision making regarding services at Gilles Plains.

In 1982 a drop-in centre was provided by government and private services and within a year, the demand was greater than the resources available. Medicare grant funding in 1984 enabled a co-ordinated health agency to be established with an underlying philosophy of providing a wide range of services at local community sites. Four staff co-ordinated services with support of government and non-government sectors. Resource sharing and diverse and flexible service delivery were integral to their community development and local responsiveness model (North East Community Health Advisory Team 1996).

In 1987 the Gilles Plains community health service expanded and changed from a Neighbourhood Centre to a District Level Health Service. The core number of staff increased to seven and the visiting agencies included mental health, counselling, speech pathology, family planning, Technical and Further Education (TAFE), child health, parenting and a food co operative. Close working relationships with health and allied professionals from nearby Ingle

Farm Community Health Service developed. After much lobbying, the North East Community Child Care centre opened its doors; prior to this, the health service itself had provided respite and short term care. In 1988, a health service reshuffle led to the Gilles Plains Community Health Service being re-aligned with the (Eastern) Tea Tree Gully health service and Ingle Farm with (Northern) Salisbury, a move that disrupted the localised collaborative networks (Gilles Plains Community Health Centre 1988). These were slowly redeveloped within the new structure.

Shut down

In 1996²³ the Gilles Plains Community Health Service was ‘temporarily’ shut down due to changes in the regional community health service structure, the development of new regional plans, and occupational health and safety issues regarding the old school buildings. This withdrawal of health services coincided with other nearby health and well-being services also being removed or wound back. The local Neighbourhood House moved to another site at Hillcrest, the Public Housing Trust decreased maintenance of homes, childcare placements became more difficult to access, community development programs were de-funded and local councils amalgamated into a larger Port Adelaide / Enfield council (Gilles Plains working party 1996). Strong community backlash to the removal of health services emerged, and a working party of community health workers, community members and representations from a range of organisations met to discuss the health needs of the north east community in the midst of this regionalisation and rationalisation period.

In 1997 Enfield Youth moved onto the campus and based their outreach services there. Financial assistance and counselling continued to be provided for adults, and funding was sought for specific community development projects. Most of the remaining social welfare activities were funded through the original, locally developed North Eastern Community Assistance Project, which relied on volunteer support, sales from the opportunity shop, and small government and private sector grants to continue providing services to local people in need.

²³ I have been unable to determine any specific information about the time between 1988 and 1996.

Starting up again

In 1998 a review of service needs in the North East metropolitan region was conducted and occupational health and safety issues addressed. Community members continued to lobby for the return of localised services and health services resumed at the Community Health Service two days per week as an outreach service from Enfield. Health professionals, many of whom had been involved in the campus for many years, formally re-committed to providing comprehensive primary health care to meet local needs. According to their meeting minutes, the challenges they experienced in successfully achieving these aims included low budgets that forced competition between sites, community health seen as the poor cousin of the health system, a trend toward providing reactive rather than proactive work, high workloads, low staffing and resources and organisational restructuring (Gilles Plains Community Health Centre 2004).

Working in collaboration with Aboriginal people

By 1999 a fourteen person reference group of local Aboriginal people and health staff formed to discuss service needs. As a result, programs at the campus increasingly focused on providing services for Aboriginal families. A Family Well-being Program, diabetes workshops, parents group, reconciliation group, gambling programs, 1-1 services, health days and domestic violence support were provided. Also in 1999, a Nunga's young mum's group began, with clients and staff support from an Aboriginal women's shelter, support services for young pregnant women, Family and Youth Services, Child and Youth Health, and parenting programs. Issues addressed included transport, parenting support, financial and school attendance. The vision was that within a year, the group would be able to run themselves (Abdullah 2002). In 1999 - 2001 there was increased emphasis and advocacy toward establishing collaborative work *with* local Aboriginal communities. A reference group of Aboriginal members and staff met monthly to guide existing and proposed activities on campus. A community development initiative began around securing an Aboriginal Neighbourhood House for the site. An Aboriginal health worker conducted a community consultation process and a joint

community and health service vision of the neighbourhood house grew and strengthened.

In 2000 a community garden/reconciliation project involving collaborative planning and decision making and cultural awareness training was initiated. The old car park in the middle of the campus was dug up and a community garden established. The opening ceremony involved Aboriginal community members providing a welcome and dance. Around the same time, primary health care services at the site were reduced from five days per week to three due to another health service amalgamation within Adelaide Central Community Health Services. The conflict between local needs and health service responsiveness due to financial and resource issues continued. The Gilles Plains Community Campus as a whole met with the South Australian Community Health Research Unit (SACHRU) in 2005 to discuss ways of improving collaboration and use of resources across the campus between health, education, welfare and community groups (Gilles Plains Community Health Centre 2004). Recommendations were made, some of which were implemented, while others were lost in subsequent policy and staff changes (reflective journal).

In 2005 when this research began the Gilles Plains Community Campus consisted of a 'mainstream' community health service that had been in existence in one form or another for approximately twenty five years and a newly developing Aboriginal Neighbourhood House. These were positioned in remodelled weatherboard school buildings. The volunteer run North East Community Assistance Program (NECAP) continued to provide food and financial assistance, a thrift shop and household goods, with some grant assistance. Also on campus was the Gilles Plains primary school, preschool, child care centre, and an Anglican Aboriginal ministry (until it closed in 2007).

In the state-wide reshuffle of health services in 2006/7, the Gilles Plains Community Health Services was to be realigned with the northern health services, but community health staff and management successfully argued that the service needed to remain connected to other central and northern services accessed by local people. During the health service reshuffle, the whole campus was refocused to prioritise the needs of young children under the age

of five years, and new arrivals/refugee peoples. A social inclusion worker was employed to build links between the school and health services (Community consultations 2005). Toward the end of 2007, both mainstream and Aboriginal community health services were directed to provide more structured and selective primary health care programs. Although Government documents theoretically supported comprehensive primary health care, Gilles Plains Community Health Service continued to experience pressure to reduce community development and ongoing support programs. Also in 2006/7 a building was brought on the campus to house the Hillcrest Neighbourhood House, to provide mainstream social, lifestyle and support programs and help to fill the gap created in the change of focus of the Aboriginal services. Unfortunately the building was deemed unsuitable and was removed unused a year later.

Local Aboriginal Health Service Development

In 2005/6 the new Aboriginal Neighbourhood House developed in line with community consultation expectations anticipation of social and emotional well-being programs and support for local Aboriginal families. A washing machine and clothes dryer were installed and three large community rooms refurbished. However, in 2006/7, the evolution of Aboriginal services changed at a higher (off site) strategic, financial, management and policy level. The emerging services became refunded partially through the Aboriginal Primary Health Care Access Program (APHCAP). This program stated an emphasis on reforming and strengthening health systems, increasing the availability of appropriate primary health care services where they were currently inadequate, and continuing to recognise and build upon the strengths and resilience of Aboriginal and Torres Strait Islander people in a respectful and meaningful way (Nunkuwarnin Yunti 2008). A partnership approach between Nunkuwarnin Yunti and the Central Northern Adelaide Health Service developed to enable a *focus on maternal and child health* with a move toward a *population health approach*, and *chronic disease management* through increasing the uptake and use of the Enhanced Primary Care Medicare Item (Nunkuwarnin Yunti 2008).

What resulted was a shifting focus from local community driven priorities and comprehensive primary health care collaboration, to externally directed,

biomedical focused selective primary health care. Changes to the structure, function and level of access to different parts of the building reflected this changing focus. Half, and then two thirds of the building became office space, clinical areas and locked rooms, to facilitate the increasing clinical and biomedical program focus. The washing machine and dryer were removed unused and replaced with an immunisation and drug fridge (reflective journal). The first official event at the Aboriginal Neighbourhood House involved staff members from across the campus being invited to join Aboriginal health service professionals for afternoon tea. While this intended to enhance collaboration between health and education professionals, the fact that it occurred prior to any Aboriginal community event being held, and that community women present were asked to leave so that health and education professionals could meet and network, was not well received by community members. They interpreted it as a sign of non-collaboration and top down decision making (Community consultations 2005).

Over time, services at the Aboriginal Neighbourhood House developed as more health professionals from Nunkuwarrin Yunti and the Central Northern Adelaide Health Service (CNAHS) were employed or relocated on site. A decision was made within CNAHS upper management that the Aboriginal Neighbourhood House would focus specifically on specific primary health care, and it was renamed the Aboriginal Outreach Health Service. Signs appeared, announcing the name change without local Aboriginal consultation or inclusion. This led to a range of community responses. This research was conducted during these changes. Further discussion of the development of Aboriginal specific services at Gilles Plains is provided in the first two Collaboration Areas, from the perspective of Aboriginal community women, and health professionals.

Gilles Plains development in a wider context

In order to place the development and changes of the Gilles Plains Community Campus within a wider health care and policy framework, I have developed the following table that identifies local, state, national and international policies in italics, and local developments in plain text.

Table 6.1 Gilles Plains development in a wider context

| Date | Event |
|-------------|---|
| 1971 | <i>Nunkuwarrin Yunti, the first Aboriginal controlled health service opens in Adelaide city</i> |
| 1978 | <i>Alma Ata Declaration of Health for All (highlighting limitations of biomedical model)</i> |
| 1980 | NECAP a community volunteer organisation begins in response to no community services in local area |
| 1981 | Multi agency Gilles Plains Neighbourhood Centre begins as an experimental project to meet the needs of lower socio economic people |
| 1982 | Drop in centre – government & private services |
| 1983 | <i>Medicare introduced</i> |
| 1984 | <i>Australian Community Health Association formed</i> |
| 1984 | A co-ordinated community health service (CHS) developed. Staff x 4 Medicare grant funding enables more services to be provided locally Community development, resource sharing, flexibility |
| 1986 | <i>Ottawa Charter – combining selective and comprehensive PHC</i> |
| 1987 | CHS expanded and changed from a Neighbourhood Centre to a District Level Health Service providing comprehensive primary health care Seven staff members with many visiting agencies Child care assistance provided |
| 1988 | Gilles Plains CHS now re-aligned with North Eastern services in health service reorganisation |
| 1989 | <i>First National Aboriginal Health Strategy</i> |
| 1991 | <i>The Royal Commission into Aboriginal Deaths in Custody</i> |
| 1992 | <i>The Council for Aboriginal Reconciliation</i> |
| 1996 | Gilles Plains CHS temporarily shut down due to: Changes in regional CHS structure, New regional plans OH&S concerns Other support services also regionalised rather than localised. Community backlash |
| 1996 | Local Neighbourhood House moved off site |

| | |
|-----------|--|
| 1997 | <i>Bringing them Home report on Stolen Generation released</i> |
| 1997 | Enfield Youth moved onto campus and provided outreach services Financial and adult support programs provided through NECAP |
| 1998 | A review of service needs in NE suburbs determines Low CHS budget Competition between sites PHC poor cousin to tertiary sector Outreach CHS resumed 2 days per week A local recommitment to PHC as discussed in Ottawa Charter |
| 1998 | <i>National Sorry Day initiated</i> |
| 1999 | A 14 person Reference Group of Aboriginal people and staff An increasing focus on Aboriginal families Family well-being, diabetes, parenting groups, reconciliation group, gambling programs, DV support, 1-1 services |
| 1999 | Young Aboriginal Mothers' Group very popular with 25-30 women attending weekly - Comprehensive PHC approach |
| 1999-2000 | An increased emphasis on establishing collaborative work <i>with</i> local Aboriginal communities. Activities included: <ul style="list-style-type: none"> • Regular reference group meetings • Planning for an Aboriginal Neighbourhood House on site • Community consultation by Aboriginal Health Worker • Reconciliation project • Cultural awareness training CHS reduced from 5 to 3 days per week due to health service amalgamation process |
| 2002 | At the end of 2002, organisational support and resources for the Aboriginal Young Mothers Group greatly reduced |
| 2003 | Aboriginal Family Well-being Course provided |
| 2004 | Aboriginal Neighbourhood House being developed in old school buildings. Extensive delays in remodelling and opening |
| 2004 | <i>ATSIC Abolished</i> <i>National Strategic Framework for Aboriginal and Torres Strait Islander health released</i> <i>Cultural Respect Framework</i> <i>South Australian Generational Health Review</i> |

| | |
|--------|--|
| 2005 | Aboriginal Neighbourhood House opened with medical services provided by GP and Aboriginal Health Workers, & diabetes group |
| 2005 | Gilles Plains Community Campus Workshop with SA Community Health Research Unit to enhance collaboration across campus (Aboriginal health not directly involved) |
| 2006/7 | Aboriginal Neighbourhood House renamed Aboriginal Outreach Health Service in line with APHCAP / Medicare funding Local community informed when signs appeared |
| 2006/7 | NE Neighbourhood House to come on site, but building unsuitable and removed unused. |
| 2006/7 | Gilles Plains CHS was to be realigned with Northern services as part of the Generational Health Review organisational reshuffle but CHS staff argued to remain in Central and North East sector. CHS Staff encouraged to reduce community development and comprehensive PHC in favour of selective primary care |
| 2007 | <i>Close the Gap campaign highlighting inequities in Aboriginal health</i> |
| 2007 | New Campus focus on children under 5 years and new arrivals/refugee people |
| 2008 | <i>First national Government apology to Aboriginal people</i> |

This table illustrates the interconnections and disconnections between local service provision and external policies and events. These events foreground many of the discussions in Collaboration Areas One and Two. It is important to note that some of the Aboriginal community members and health professionals have been involved with the campus for as long as, or longer, than the community health services has been open (since 1981). Others are more recently connected, and know little of past events. This has led to a diverse range of perspectives and responses to events occurring during this research.

Aboriginal health worker involvement with the campus has varied. Short term employment contracts and organisational and policy changes have determined levels of involvement. At times, Aboriginal health workers have been positioned in community locations including Gilles Plains as part of regional multidisciplinary primary health care teams. At other times the Aboriginal health workers have been based in an Aboriginal Health Team, providing outreach services across the region. These changes reflect differing management and policy strategies regarding community engagement, collaborative partnerships, specific health promotion programs, and workforce development, as discussed in Chapter Three.

Both Aboriginal and non-Aboriginal community health professionals and managers have struggled to provide client centred care over the last twenty five years (community consultations with health professionals and past and present managers at Gilles Plains, 2005). Low budgets, high workload, low staffing and scarce resources have made this challenging. As discussed in Chapter Three, the community health budget has at times been only received 5% of the total federal health budget (Australian Institute of Health and Welfare 2006), and frequent policy changes and restructuring have impacted on continuity of care. Despite these challenges and changes, a strong culture of collaboration, consultation and evidence based practice has generally been sustained by multiple agencies at the campus over the years (Aboriginal Health Services Interagency Forum 2001; Gilles Plains Community Health Centre 1988, 2004; Program Review Group - Community Health Enfield 1998; Stark & Coulls 2007; World Health Organisation 1978).

Surrounding demographics

The Gilles Plains Community Campus is located in the north east suburbs of Adelaide, on the boundary of Port Adelaide Enfield, Tea Tree Gully and Campbelltown municipal council areas. The surrounding suburbs consist of some public housing (including Aboriginal housing), new redevelopments of private homes, and commercial and light industry. A high school and adult education centre are within walking distance, and an Aboriginal women's shelter, disability support services and the men's and women's prisons are located in nearby suburbs. People living locally consist of long term residents, people moving into the area in the new housing developments, public housing or to stay with family, and newly arrived refugees from mostly African, European and Middle Eastern countries. Some families have lived in the area for generations, with their children and grandchildren attending the Gilles Plains Primary School, others have only newly arrived to the area.

According to Australian Bureau of Statistics (ABS, 2007) data, Aboriginal people make up 1.7% of the total South Australian population and 5% of the total Aboriginal population in Australia. In the Gilles Plains (Enfield East) area 57% of Aboriginal people living in the area are under the age of 25 years, 30% are aged 25-44 years, 8.8% are aged 45-64 years, and only 1.8% are over the age

of 65 years (South Australian Aboriginal Health Partnership 2005). This means that fewer adults are caring for more children and young people in Aboriginal families compared to in non-Aboriginal families.

Of the 964 Aboriginal people recorded as living in the immediate Gilles Plains (Enfield East) area, 11.5% identified as speaking Aboriginal and Torres Strait Islander languages and 74.4% spoke English only. Eighty four percent lived in private dwellings and 15.5% in non-private dwellings which may include hostels and women's shelters. Equal numbers of men and women lived in the area as long term residents in private or rental houses, new residents seeking Aboriginal housing, or visitors from different areas of the state or interstate staying with family or at the Aboriginal hostels. There were no sleepers out/homeless people recorded on the survey.

Employment statistics were that 70% were employed, with 3.7% of people in CDEP programs. Unemployment rates were 28.7% for women and 30.7% for men. Higher education questions indicated that 63 of the 964 (6.5%), people had certificates 19 (2.0%) had an advanced diploma or diploma, 14 (1.5%) had a bachelor degree, 5 (0.5%) had a graduate diploma or certificate and no one had a postgraduate degree. 269 children were attending school with 207 of these aged below 15 years. This indicated that 84.5% of students aged 5-14 years were attending school, and that 15.5% were not. Numeracy and literacy levels were below the state average according to the Department of Education and Children's Services 2004 numeracy and literacy testing. The numbers of community service orders and imprisonments were above average for the general population (South Australian Aboriginal Health Partnership 2005). Hospital separation data suggests that hospital visits relate to renal and circulatory disease, mental health, diabetes, asthma and pregnancy and childbirth, as well by alcohol, substance and tobacco related issues.

My involvement with Gilles Plains as a nurse/researcher

As a community health nurse I first became involved with the Gilles Plains Community Campus when I was invited to talk with a group of young Aboriginal women about contraception at the Gilles Plain Young Nunga Mum's Group in 2000, and again in 2001. I began working with Aboriginal

women more regularly while co-facilitating their group and providing clinical services. In 2004 I attended a Family Well-being Training at Gilles Plains alongside Aboriginal community women, conducted a small participatory action research project and began providing sexual health clinical and health promotion services on site.

Summary

In this chapter I have provided an overview of health service development at the Gilles Plains Community Campus. At times health professionals have been supported to be based *at* Gilles Plains, working collaboratively *with* local residents and local services in democratic partnerships, addressing locally identified needs. During these times, relationships of trust and reciprocity were formed between health staff and Aboriginal community members (Aboriginal Health Services Interagency Forum 2001; Gilles Plains Community Health Centre 2004). Bottom up policies enabled local priorities and issues to be addressed in ways considered most appropriate by community members, local health professionals and onsite managers. *Evidence based practice* incorporated external biomedical and policy knowledge as well as local community, individual client, local health professional and managerial knowledge. Decisions were made in the context of people's lives guided by concepts within comprehensive primary health care, community development and capacity building programs and policies. Specific expectations regarding democratic knowledge and power sharing, working together collaboratively and addressing issues in locally meaningful ways were established between health professionals, community members and managers.

At other times, organisational and health policies focused on mainstreaming and centralisation, with top down decision making and external changes. During these times, staff were taken off campus and/or directed into specific primary care programs resulting in relationships with community becoming strained, and local community expectations largely unmet (Community consultations 2005). When this coincided with other support services being removed from the area, there was strong community backlash. Evidence based practice during these times was considered (by top down policies) to be based

on external and biomedical, economic and statistical priorities, rather than locally identified needs.

Chapter 7 Collaboration Area One - Local Aboriginal Women's Priorities

Overview

In this chapter I discuss how four local Gilles Plains Aboriginal community women co-researchers and I worked together to address *their* most pressing women's health and well-being needs. This first Collaboration Area explores the possibilities and challenges of democratic knowledge sharing, working together in collaborative action, and addressing colonising, discriminating and exclusionary practices through working in partnership with Aboriginal community women. As guided by Aboriginal health research ethics, I focus on both the *process of* developing, enacting, experiencing and evaluating our collaboration, and *the outcomes*. Together we adapted Stringer's participatory action research and in the process, created a model of collaborative practice suitable for health care and research involving Aboriginal community members. Tangible outcomes included the development of a women's friendship group, identifying and making choices, and co-presenting our findings at conferences and workshops. Importantly, this chapter focuses on these Aboriginal community women's experiences and knowledges at a time when they were feeling unheard and unacknowledged. It is necessarily a long chapter, because it honors an agreement made with the four community women and the Aboriginal Reference Group that a discussion of past and subsequent events from the four Aboriginal women's perspective would be included. My history and changing role working with the women is also purposefully 'written in', highlighting the importance of developing relationships over time.

Methods

Community consultations, semi structured interviews and focus groups with trigger questions and document analysis were used in this Collaboration Area. Together the Aboriginal community women (co-researchers) and I co-developed locally appropriate participatory action research with repeated cycles of Look and Listen, Think and Discuss and Take Action. I invited stakeholders (those who influenced or were influenced by the research) to

participate in semi structured interviews, and added their interpretations, analysis and perspectives to the data pool.

Co-researcher selection

Only four local Aboriginal community women were actively involved with the Gilles Plains Community Campus when this research began in early 2005. These women had been part of the community consultations and were keen to be involved as active co-researchers. They had been involved in health and community activities over the previous five to fifteen years. All four women cared for children who attended the Gilles Plains Primary School. Up to five other Aboriginal community women, and five non-Aboriginal community women (1 Non-Aboriginal and 4 Maori) became involved in collaborative activities such as the women's friendship group and health days and are positioned as stakeholders. The core research planning, data collection, interpretation, analysis, and activities involved the original four women.

Stakeholder selection

Five Aboriginal and non Aboriginal health professionals from the Gilles Plains Community Health Service and newly developing Gilles Plains Aboriginal Outreach Health Service were interviewed as stakeholders. One onsite manager and three higher level (offsite) Central Northern Adelaide Health Service Managers responsible for overseeing health care at Gilles Plains were interviewed. Aboriginal mentors and Aboriginal Women's Reference Group members commented on findings.

Discussion of PAR cycles

This chapter follows the progression of PAR cycles, reflecting the intertwined feedback loops between data, interpretation and action, co-researchers and stakeholders²⁴. Rather than 'neatly presenting' the total data collection, analysis, and then outcomes, this chapter follows the journey of our emerging cycles of awareness (data collection *look and listen*) knowledge sharing (story telling, interpretation and thematic analysis *think and discuss*) and

²⁴ The phases of these cycles are indicated in the footnotes to avoid confusion of multiple headings in text.

collaborative action (*take action*) as they developed. This ensures that the women's voices, decisions and actions remain **in context** of what was happening around them and for them at the time, an important consideration in woman-centered postcolonial feminist studies. Further analysis based around the three central themes of knowledge sharing, working together and addressing issues is positioned at the end of the chapter.

Negotiated coding

In order to include the women co-researchers and stakeholders' voices and viewpoints, but not identify them as individuals (which is what they specifically asked for), I devised the following coding system. AWG D refers to discussions with the small group of four Aboriginal community women. WFG refers to discussions with the broader membership of the Women's Friendship Group open to a wider group of Aboriginal and non-Aboriginal women. AHS D refers to discussions with Aboriginal health staff and CH D refers to discussions with community health staff. Mg refers to managers.

Background – building relationships and expectations

As strongly encouraged by Aboriginal women co-researchers, Aboriginal Reference Group, I begin this chapter with a historical account of events and relationships between the Aboriginal community women, the Gilles Plains health services and myself. Aboriginal co-researchers (AWG D7) discussed that often this aspect is over looked in reports and studies, and yet from their perspective it makes the difference between whether a program or research works or not.

A culturally safe meeting place - Aboriginal Young Mothers' Group

The four Aboriginal community women (who later became co-researchers) and I first met at Gilles Plains Community Health Service. I was invited by an Aboriginal Health Worker to provide a contraceptive workshop for the Gilles Plains Aboriginal Young Mothers' Group in 2000. This parenting group was highly regarded by the Aboriginal women who attended (community consultations with Aboriginal community women 2005). It was supported by Aboriginal Health Workers and Registered Nurses from Gilles Plains

Community Health and Child and Youth Health services²⁵. It became a popular, well resourced, capacity building and comprehensive primary health care program with childcare, transport and catering facilities provided (Abdullah 2002). The program was run *in a quiet way, empowering young Aboriginal women to take control of their own health and well-being* (Abdullah 2002). It aimed to meet participants' comprehensive needs, by providing flexible and responsive parenting courses, first aid lessons, art and craft, driving license instruction, general health discussions, baby and child health checks, career planning and financial assistance. The workers strove to combine cultural safety, women's health and well-being, and comprehensive primary health care in flexible and respectful ways.

Twenty five to thirty women attended each week. Most were young Aboriginal women, but the group also included Aboriginal GrandMothers' in recognition of their role as primary carers for their grandchildren. Over time, group members increasingly supported each other and met at other times during the week (Community consultations 2005). Workers noted that the requests for one to one services with health professionals were reduced as a result of this increased networking within the group (Abdullah 2002). The Gilles Plains Young Mothers' Group became well known across the north eastern suburbs as a meeting place for Aboriginal women, and many agencies sought permission to come and talk with the women about upcoming Aboriginal programs and projects (Abdullah 2002; Community consultations 2005).

Early in my visit, one of the oldest Aboriginal women began strongly questioning me about who I was and where I stood in relation to colonisation practices and inequalities. She spoke about a history of health professionals forcing Aboriginal women to use contraception without consent, and midwives' involvement in taking away Aboriginal women's babies. Having worked in Aboriginal health for some time, I recognised that she was testing my motivation and responded as respectfully as I could. I acknowledged that there is a history of non collaboration and that my intention was to offer information about contraception so that Aboriginal women could make an

²⁵ At that time both Child and Youth Health and the Adelaide Central Community Health Service favoured Aboriginal health worker / community health nurse partnerships within multidisciplinary teams.

informed choice themselves. I invited her to participate and add cultural perspectives during the contraception discussion, so that we could have an open and frank discussion. She found my suggestions acceptable, and the session progressed with her input.

In mid 2002, I was invited to return to Gilles Plains to provide a “Just Chillin” holistic comprehensive primary health care stress reduction and well-being program for the group. I encouraged the women to brainstorm what they would like to do and together we developed a program for the following three months. The women chose aromatherapy, bush walking, sewing and craft work as well as women’s health and parenting information. The resulting combination of health promotion information and relaxing and productive activities were very well received (Just Chillin Report, 2002).

Learning about each other through Family Well-being

A Family Well-being course was planned for 2003. Family Well-being is a life skills capacity building and counselling course developed in conjunction with Aboriginal communities. It focuses on recognising the effects of colonisation, conflict, violence and abuse, and aims to move participants from positions of anger and conflict to negotiation and heart centred spirituality (Family Well Being Group 1998). I indicated an interest in attending a Family Well-being course, having heard about how positive and successful they were in addressing deeper issues related to colonisation, grief and loss and community disharmony. The Aboriginal women and workers invited me to attend.

When we returned the next year, the women and I discovered that unrelated but concurrent health service and staff changes had resulted in the withdrawal of support and resources for the women’s group by all three health agencies involved. Child and youth health services had moved away from support groups to universal home visiting, the Aboriginal health team had centralised and were increasingly focused on chronic conditions, and the Gilles Plains community health experienced staff changes and a move away from supporting Aboriginal parenting programs in anticipation of the new Aboriginal Neighbourhood House opening on campus. The result was that only the few women whose children still attended the local school and kindergarten, and/or

those with private transport were able to attend the Family Well-being Course and remain in contact with the Gilles Plains campus. I became the only health professional directly involved with the group, and by default became the link person between the Gilles Plains Community Health Service, the Aboriginal Mum's Group and the Family Well-being facilitator. I temporarily took the role of co-facilitating transport, food and childcare as a co-located worker, while also being a course participant. This 'temporary situation' continued all year.

Being involved in the Family Well-being program provided me with many opportunities to listen, learn, reflect, challenge ourselves, share and grow alongside Aboriginal community women under the guidance of a very experienced and compassionate facilitator. I learned about the personal effects of colonisation, discrimination, exclusion and inequities by listening to the stories of those around me. I learned to listen deeply with my heart as well as my head, practising *Dadirri* as described by Judy Atkinson (2002) and Ungunmerr (1993). Cultural exchange and cultural permeability (Mataira 2003) increased as we came to trust each other and share our experiences and thoughts more deeply. We came to understand each other as women who both shared and had differing life experiences. In gentle Ganma two-way knowledge sharing we came to understand more about who we were as individuals, and in relationship to each other (Gullingingpuy 2007; Pynch & Castillo 2001).

The family well-being facilitator encouraged us to move toward being personally accountable for who we were, and what we chose to do, while recognising the complex structures and dynamics in situations that can prevent us from taking positive action (Family Well Being Group 1998). I came to see the health system from a different perspective, as a series of people and organisations that may enable or exclude people from its services. I grappled with my own whiteness and the impact of colonisation, coming to understand more deeply the inherent privilege I hold as a white woman in Australia (Frankenburg 1993; Moreton Robinson 2002). As described by Christine Franks, I learned *not to be the enigmatic all-seeing all-knowing professional*. Rather by first listening deeply, while withholding my own cultural baggage, I

came to understand other world views. Over time I realised the importance of *endeavoring to give something of myself in all interactions* (Franks & Curr 1996, p. 109), to break down the barriers created through Western professional behaviours. Looking back I realised that this course was a crucial step in me learning how to work with accountability and respect in collaborative health care and research. I learned to move past artificial professional barriers that kept my emotions safe, instead connecting with the women around me, listening deeply and compassionately. I allowed myself to be human and vulnerable, accountable and connected. I learned to work in ways described in Dadirri and Ganma.

Toward the end of the year, plans were made for the fifth term of the Family Well-being course to be held in 2004, enabling participants to become trainee facilitators themselves. I was not able to commit to supporting or attending this due to conflicting commitments. The Aboriginal Neighbourhood House was near completion the course was to be held there, supported by the new Aboriginal health team. Delays to the opening and staffing of the Aboriginal Neighbourhood House occurred, but the women were welcomed in by the manager and spent term one of 2004 in the Aboriginal health building having full access to the building, including photocopier, kitchen and community group rooms (Gilles Plains Community Campus 2005 - 2008). The Aboriginal women felt a sense of ownership and relief that the long awaited Aboriginal Neighbourhood House was finally available, and that they could access it as planned for so many years. Unfortunately, changes in the role and function of Gilles Plains Aboriginal services soon changed this dynamic, and the Aboriginal Neighbourhood House became an Outreach Health Service. These significant changes are discussed later in this chapter.

Researching and working together prior to this research

During 2003, I invited the same four Aboriginal community women to become involved in a research project focusing on sexual health nurses and meeting the needs of young Aboriginal women (Kelly 2004). The Aboriginal Family Well-being facilitator assisted me in explaining research, confidentiality, informed consent and personal choice, stressing that participants could freely decide whether to be involved or not. All of the women chose to be involved, and our

collaborative research led to increased sexual health services at the Gilles Plains Community Campus²⁶. The four women became involved in creatively and effectively promoting the clinic, distributing clinic flyers to Aboriginal and non-Aboriginal women at schools, bus stops and shopping centres.

Community consultations –planning this research

In 2005, I began this research process by consulting with *local Aboriginal community women* as those most affected by, and usually with least choice about, health service provision. The same four Aboriginal community women were the only Aboriginal women connected with the campus at this time, and they all became involved. When I asked what the focus for this research should be, they spoke of their priority and the need to address the stresses in their lives, which they related to the daily task of *caring for families, dealing with discriminating people, police involvement, money concerns and dealing with health, education and welfare systems* (AWG D1). They said that when they had been able to attend a supportive women's group such as the Aboriginal Young Mum's Group or the Family Well Being Group they had been able to cope more effectively. In the time since these programs finished *nothing else filled the gap*.

These programs had also provided a positive meeting place and social space for them. One woman explained;

There is no where for us (Aboriginal women) to meet in this North Eastern part of Adelaide except the pub, pokies or car park. If we go to the pub, even for a lemon squash, people assume we are getting drunk. The Cafes are too expensive and people look at us funny. We try to avoid the pokies. Our homes are too small, or we have other people living there. That leaves the car park. It would be nice if we could meet somewhere other than the car park (AWG D1).

In addition the women said that they had felt comfortable accessing health information for their family and themselves as part of the group, in ways that they didn't as individuals. Eighteen months after the group discontinued, the women still felt the loss acutely. One woman said *it feels as if they have cut off*

²⁶ There was also a formal request from Gilles Plains Community Campus for increased services.

a life line, again' (AWG D1). When asked who *they* were she spoke of *white managers high up in the health system; the boss who makes these decisions without taking our needs into account* (AWG D1). The cessation of the group became seen as *yet another colonising experience* for her (AWG D1). A year and a half after the group finished, the women expressed feelings of sadness and anger. They had unanswered questions about what had happened to the groups they valued and *who was to blame* for them being stopped. The women indicated an interest in being involved in research again, with a particular view to planning and taking collaborative action together.

Woman centred research

Following ethics approval I returned to Gilles Plains Community Campus and invited the women to be involved in data collection discussing Aboriginal women's health and well-being²⁷. Originally I had anticipated discussing the concept generally, but the women wished to discuss it in relation to the services available at Gilles Plains, their current dilemmas and highest priority. Following principles of community based research (Stringer 2007) and Aboriginal health research ethics (Chong 2005b, 2005c; National Health and Medical Research Council 2003) I went with the women's priorities.

The long awaited Aboriginal Neighbourhood House opens, but...

The Gilles Plains Aboriginal Neighbourhood House had recently opened and the services provided were vastly different to those anticipated by both Aboriginal community women and the mainstream community health service who were involved in its conception and early development. The original vision for a community meeting space that could provide support and social and emotional well-being programs was no longer supported by higher management in the local health system. A series of events occurred. First the onsite Aboriginal manager, well known by the women, became ill and took extended sick leave. Second, the social and emotional well-being team was

27 *Look and Listen- interviews, focus groups & document analysis*

relocated to another site in an organisational reshuffle²⁸ (Community consultations 2005). Third the funding for staff positions and programs became linked to Medicare Aboriginal Primary Health Care Access Program funding. As a result of these three events, the first services to be provided at the Aboriginal Neighbourhood House were a medical clinic, diabetes program, and school based health expos. The local Aboriginal women asked what was happening about the women's group or craft group that they had discussed with the original manager. A room was made available for them to *come in and do craft* without worker support.

The community women discussed their feelings about what was happening in ongoing research meetings, interviews and focus groups. They spoke about feeling increasingly out of place at the Aboriginal Neighbourhood House. After *having access to the whole building during the Family Well-being Program*, they now felt *that they didn't belong* (AWG D2). The women said they were finding it difficult to get their needs recognised and met amongst the increasing clinical focus and securely locked cupboards and doors that developed within the Aboriginal Outreach Health Service. It often took up to an hour for the clinic receptionist to become available to unlock the art cupboard in the group room. When the clinic was cancelled they arrived to find the building locked. Signs had appeared announcing that community members were not to use the telephone, kitchen, photocopier or fax, when previously they had access to these amenities.

The women discussed mixed feelings about the changes. One said;

The new clinic is good, but hopefully it is not being provided at the expense of the social and emotional well-being programs and community meeting space that we have lobbied for over many years (AWG D2).

Another woman explained;

We thought we could go there for help outside of health stuff, and that it would be a meeting place. At the moment there is a lack of

²⁸ It was originally envisioned that the Gilles Plains Aboriginal Neighbourhood House would focus on social and emotional well-being and this intention was discussed in regional meetings in late 2004. However this intention changed at a higher management level (I have been unable to determine exactly how and way) and the team were relocated to a Western location.

communication, maybe they are finding their feet as well. Lots of people come and go; managers and staff, the trust stuff that we talk about is a big thing for us. The manager we knew has gone now. We are always meeting new faces, we don't know them and they don't know us and our struggles. They don't know that we have been part of this for so long, that we helped to plan this service. It is like Johnny come lately. It feels like we are in the way, that there is no place for us there.

I have to say though that the doctor and counseling service is good. When I was desperate I did finally go there and they were very helpful (AWG D2).

These comments reflect community perceptions of the changing focus from community development and support to clinical services and chronic illness prevention.

As a nurse researcher listening to these experiences and reflections, and reflecting on the literature review I began to suspect that some of the issues were linked to the differences between comprehensive primary health care and selective primary care. I brought these concepts to the women to see if my thinking was correct, and perhaps assist them to make sense of the confusing situation they found themselves in. I aimed to do this in the way of Belenky and colleagues (1973) through supported midwife and connected teaching styles that enabled the women to develop their own knowledge²⁹.

Exploring unmet expectations

I asked the women which services on campus met their needs most readily. They identified the Nunga Lunches and computer classes at the Aboriginal Neighbourhood House, the North Eastern Community Assistance Program (NECAP) and the Community Health Gardening Group. When we discussed why these were preferred they reflected that these services were *welcoming, provide friendship and companionship, meet our immediate health and well-being needs, and help us develop skills we need for life and work* (AWG D2).

²⁹ *Think and Discuss- analysis and interpretation -making Ganma foam*

I asked them what else they were seeking that was not readily available. They discussed;

financial, transport, utility and welfare concerns, needing assistance to support family members with specific health problems or who were in trouble with the police, further education and training options, preparation for employment, learning to use computers, getting a drivers license, assistance with public housing, legal concerns and dealing with grief and loss (AWG D2).

When I explained the differences between comprehensive primary health care and primary care (World Health Organisation 1986), the women agreed that they were seeking services more in line with comprehensive primary health care and community development to address a wide range of issues in their lives. The services currently on offer at the Aboriginal Neighbourhood House were medical, clinical, counseling and chronic conditions focused, linked to specific primary care health issues. While those services offered some aspects of comprehensive primary health care, there was little support for their wider health issues and programs such as the kind of women's group they envisioned.

Once we had identified the gap, we then discussed what to do about it. Sitting together in a focus group in the community health building (their venue choice), we used butcher's paper and Texta pens to brainstorm possible options. First we wrote about the women's concerns, expectations, and what had eventuated, ensuring that everyone had opportunities to voice their opinion. This enabled everyone to feel that their concerns had been heard and acknowledged, freeing them to move forward into possibilities. Once we had exhausted the list, we set it aside.

Following the advice of Kim O Donnell (Aboriginal health research mentor), I invited the women to envision where they would like to be in five years time, focusing attention on future possibilities rather than current health service limitations³⁰. Utilising our Family Well-being training, we discussed the importance of changing the dynamics from being *victims* or *combatants* of the

30 Taking Action -considering options, making choices

health system, to *actively choosing* what to do in relation to the services currently available³¹. The women came up with four options;

1. Keep trying to develop an Aboriginal women's group at the Aboriginal Neighbourhood House
2. Attend what ever program is provided because '*anything is better than nothing*'
3. Join with Aboriginal / women's groups off campus
4. Start a women's group ourselves

Over the next few months the women tried the first two options individually and collectively. They continued to meet as a group of women at the Aboriginal Neighborhood House and most attended the new Aboriginal diabetes group, computing course, Nunga Lunch and the Community Health gardening group.

Growing disharmony

The women and I met in a focus group a few months later to evaluate the actions planned³². The women said the situation at the Aboriginal Neighbourhood House had not improved significantly for them over the last few months. They spoke of *continual changes of staff, including management* and staff members who were *unable or unsupported to make decisions themselves* (AWG D3). They suggested that this contributed to the lengthy delays in community requests being responded to. Communication between some of Aboriginal community women and Aboriginal health service staff had become strained and at times erupted into arguments. Signs continued to appear without discussion such as *Do not use the phone; Do not smoke here; and Do not use excess tea and coffee*. Three of the women took these as a personal attack and had responded to them by passively withdrawing (passive resistance), ignoring them, or becoming more argumentative (*active resistance*).

Some of the women discussed that their home and financial situations had worsened, leading to them no longer have access to a telephone at home. This made *arranging appointments for family members with health and welfare*

³¹ These choices link to postcolonial resistance and transformation discussed by Ashcroft (2001a) in the postcolonial theory section of Chapter Four.

³² *Look and Listen again - evaluation and review*

concerns, connecting with family members living in other parts of Adelaide or Australia, and arranging transport to get to funerals incredibly difficult (AWG D4). The women felt that the Aboriginal health service should make a phone available, just as the community health service had over the years. They saw it as a *basic health need*.

The appearance of 'no smoking' signs created specific concerns. Signs had appeared without explanation and the women were told they had to go out onto the street to smoke. One of the women said that this made her feel *quite unsafe, a target for anyone passing by*. Another discussed that the situation fed into the stereotype of Aboriginal people *having nothing to do, hanging around smoking on street corners* (AWG D4). They felt that the Aboriginal health staff should know this, and the signs were inappropriate.

Considering other perspectives & effective communication

As a health professional that attended campus meetings, I was able to offer another perspective to the motivation behind some of the signs that were so inflammatory for the women³³. The entire Gilles Plains Community Campus including health buildings was Education Department owned, and a new state wide directive had been sent out that smoking was prohibited on all school grounds. This meant that staff and visitors had to smoke off campus. I then wondered aloud whether the limitation on the use of phones, tea and coffee were linked to budget cuts, and rulings from higher (offsite) management, rather than decisions made by onsite staff. We discussed the abolition of ATSIC (Aboriginal and Torres Strait Islander Commission) in 2004, and that many Aboriginal organisations felt that they were under increased scrutiny.

The women discussed these points at length, and said that this extra information changed the way they felt about the events. They still didn't like the end result, but it no longer felt so much like a personal attack against them specifically. They wondered *why no one had taken the time to explain these things*, or let them know about the signs *before* they went up. Together we

³³ In the *Look and Listen* phase it was important that I listened intently with few comments. In the *Think and Discuss* phase, I began to offer another viewpoint and additional information as described by Stringer (1973)

reflected that what was missing was effective communication and information sharing between the women and staff members.

Having identified the importance of effective communication and information sharing, we all discussed how the situation could be improved. Using Family Well-being strategies, we envisaged moving from conflict to negotiation. After much discussion, the women decided that *some of staff members were more approachable than others*, and that *two of the community women had better relationships with staff than others* (AWG D4). Two other community women self-identified as having had heated arguments with staff members over the last few months. Collectively, the women decided that those in positive relationships would become the key communicators and those who were arguing would try to take deep breaths or leave the building if they were angry so as to not jeopardise improved communication between community and health staff. The women noted that the original Aboriginal manager who they all liked and respected had returned and was actively discussing the women's request for a women's group. The women unanimously decided to keep interacting with the Aboriginal Neighbourhood House, hopefully in more positive ways, and attend the women's group when it started.

Stakeholder perceptions

As well as working directly with the Aboriginal community women co-researchers, I also interviewed and had less formal discussions with stakeholders³⁴. These were made up of Aboriginal and non Aboriginal health professionals ($n = 5$) and manager ($n = 1$) at the Gilles Plains Aboriginal Neighbourhood House, Gilles Plains Community Health Service health professionals ($n = 2$) and manager ($n = 1$), and Central Northern Adelaide Health Service Managers responsible for overseeing health care at Gilles Plains ($n = 3$). While most of the data from stakeholder interviews is discussed in the next chapter, some aspects are relevant to this Collaboration Area.

Stakeholders provided a range of perspectives about what was occurring, what was possible, and what was impacting on effective collaboration between Aboriginal women co-researchers, health professionals and other stakeholders.

³⁴ Stakeholders being those who influence or are influenced by the research.

Mainstream community health staff members discussed *not wanting to intrude while the Aboriginal health services get established, and offering to work collaboratively when the Aboriginal health service is ready* (CH2). Intermingled with this *sit and wait* approach was an understanding of, and concern about, the wider historical context impacting on relationships between the Aboriginal community women and the newly developing Aboriginal services. One community health service stakeholder said;

... there has been a loss of continuity, because one service has closed down and there was a gap before the next one has reopened and it has come reopened in a different form. As you know there is that tension between the community people that have been there for a long time, who actually advocated and worked very hard to get the service up, and now it is not theirs anymore because it has become a more top down service that has got accountability requirements broader than here.

I realised recently that no one in the current Aboriginal health team really understands the history of the community campus, that they did not know all of the things that that the Aboriginal women have been doing over the years. In some ways they were only noting the negative connotations and not the positive things and the years of effort and commitment that the women have been putting in.

They also didn't seem to know the history of what was originally planned for the Aboriginal Neighbourhood House versus what is now being provided and so they do not understand why the women go in and 'sabotage' programs and projects.

Staff will need to find ways to work with community who have been waiting for a long time, they can't just overlook them. They need to work with them as well, because if they don't it will just cause problems. I think that there are some issues about communication, perhaps new staff and the people making decisions now don't fully understand what the issues are for the community here (CH1).

This account reflected what the women were saying. Newly employed staff members at the Aboriginal Neighbourhood House had little concept of the wider historical issues, the community consultations and years of collaboration

that had led to the development of local Aboriginal services. They were employed to fulfill a particular selective primary care role within a developing health service and at times could not understand why there was such opposition by local community members.

The manager of the Aboriginal Neighbourhood House at the time (there were five managers during the first year) spoke of specific funding and policy decisions that were driving service provision at Gilles Plains. She explained that;

Medicare linked Aboriginal Primary Health Care Access Program (APHCAP) funding had enabled the Aboriginal Neighborhood House to be developed, and as a result programs needed to be focused on clinical services and chronic conditions prevention (Mg 2).

Two health professionals employed under APHCAP said that while they understood what services the women were requesting, they had no resources to provide them (AHS D4)³⁵.

Many staff members suggested that there were no longer spaces for *warm and fuzzy programs* like the women's support group that the Aboriginal women were searching for within the health sector due to an increased focus on selective primary care and chronic conditions programs (AHS D2). They suggested that the Aboriginal women would be better to focus their attention on the mainstream North East Neighborhood House that was planning to move onto the Gilles Plains campus soon. They felt that this service could better meet the social, support, craft and well-being programs the women were seeking.

³⁵ Through later discussion I discovered that the services at the Aboriginal Neighbourhood House were jointly state /federal funded. Some staff members were employed by a central Aboriginal Health Service Nunkuwarrin Yunti with federal Medicare linked APHCAP funding. Others were employed by the Central Northern Adelaide Health Services (CNARS) through state funding. There were confusing federal/state funding and accountability expectations, short term contracts, and differing expectations. Some programs were jointly federal/state funded and delays occurred while arrangements were made between the two. In addition, the state Generational Health Review and reshuffling of the health services was resulting in changes in management and staff across the local health region.

‘Why are you working with those women?’

My decision to work with the community women as co-researchers was questioned by Aboriginal Neighbourhood House staff members (who were both Aboriginal and non-Aboriginal). One said *the women show you their good side but really they are very manipulative* (AHS D2). Another; *some of the community women are verbally attacking us and we find it very distressing* (AHS D2). I was told *you pandering to their needs, is not helping the situation* (AHS D2). More than one staff member said that the community women in question *did not mix with other community women and monopolised any services provided and kept other women away* (AHS D2).

My involvement with the community women was also questioned by Aboriginal managers on and off site. One said *your name gets brought up as the person who is going to solve the problem with these women* (Mg2). Another (Mg3) suggested *you should not work with this group of community women as they are manipulative and will negatively impact on the research*. I was told by two managers that *some of the women you are working with are involved in a community lobby group that have put forward a vote of no confidence in Aboriginal management*. This explained some of the hostility I was detecting.

Navigating an ethical dilemma as a nurse/researcher

As a health practitioner I heard in campus meetings that management planned to change the name of the Aboriginal Neighbourhood House to the Aboriginal Outreach Health Service in keeping with its newly defined primary care role. I enquired whether anyone was intending to explain this to community members, and was told that of the plan *to put up the sign announcing the name change, and then deal with the fall out*. There was an expectation that I would collude with this non-communication as a co-located campus staff member. This presented me with a significant ethical dilemma. While on one level I recognised management motivations for preventing community opposition before the name change, I could imagine only too well that this act of non-communication would be felt deeply by community members. As an employee, I was bound to certain confidentiality; as a nurse researcher I was committed

to transparency, knowledge sharing and respectful partnerships. I was faced with an ethical dilemma. After much consideration, I decided to discuss with the community women how they could deal with further changes should they occur, without disclosing exactly what they might be.

I met the Aboriginal women co-researchers (AWG D5)³⁶. They were generally despondent. They discussed the name change from Aboriginal Neighbourhood House to Aboriginal Outreach Health Service as *having their concerns confirmed*. I detected resignation and sadness as well as anger. These 'quieter' responses seemed to fit with management's plans, but were very concerning for me as I detected that some of the women's sadness bordered on despair. One of the women vocalised how the changes at the campus, along with being unheard or ignored in other aspects of her life, reminded her of other life long colonisation, exclusion and discrimination practices. She said;

They are not listening to us. They set the rules and that is that. We don't have a voice, our opinions are not valid, and people just don't listen to us. It is not OK for us to say what is hurting us. It is like another bag of poison flour. We don't trust easily, memories were passed down. A lot of us give bad attitude. We are hurting. We need to have each other, and support. Without the group I am falling apart (AWG D5)

These written words do not adequately convey the level of emotion this woman expressed.

A women's group, but not for us

Along with the name change, other events had occurred. The manager that the women all knew and liked at Gilles Plains Aboriginal Neighbourhood House was relocated and a new manager brought in. The jointly planned Aboriginal women's group was cancelled. Instead a young women's social and emotional well-being and craft program was planned, provided by one of the social and emotional well-being counselors. Aboriginal health service staff clearly stated that this program was created for young Aboriginal women, not the four community women involved this research. However, very few young women attended, and the women ended up becoming involved.

36 Think and Discuss - co-researcher perceptions, interpretation & evaluation

They explained;

We saw the worker in there all by herself with all the craft items, so we wandered in to say hi and to support her group. We knew the other staff didn't want us there, and we weren't really welcome, but it was just what we had been asking for. All the craft items sitting there, waiting to be used, and a worker to give support (AWGD5).

Their involvement met their immediate needs, but triggered more tension between staff members and themselves. One of the Aboriginal health staff said to me *and of course those women came in and took over, again (AHS D4).*

Being referred to services that never eventuate

The women were directed to attend programs at the North East Neighbourhood House. Unfortunately after months of anticipation, a building came onto the campus, remained empty for months due to occupational health and safety issues related to the design and structural materials, and then was removed unused. The North East Neighborhood House continued to provide existing services in a nearby suburb but was not accessed by the Aboriginal women due to transport and location constraints. The women summed up their opinion by saying *once again we were encouraged to wait for a service or program that never happens. Do we need to spend our whole lives waiting? (AWG D4)*

The Aboriginal women's health day – good for a day

Amidst these happenings the first Aboriginal Women's Health Day was held at the Aboriginal Outreach Health Service. I had been working with Aboriginal health staff at Gilles Plains to plan a positive health promotion event. Two of the Aboriginal health staff co-researchers and I were hoping that this event could help heal some of the animosity between the community women and Aboriginal health staff members. The community women came in early and helped to set up the community room and participated throughout the day, assisting with decorations, food preparations, painting and arts and crafts. They said that the day *felt good*, that it *felt like a community space for the day*. However they all agreed that it was a one off, and they were seeking ongoing programs. One woman reflected *it was good for a day, and then it all went*

back to how it always is, and we were just in the way again (AWG D4). I too observed that for a day, the community room at Gilles Plains Aboriginal Neighbourhood House felt like a jointly owned community space, where the barriers were lowered, and then the next day the barriers rose again in accordance with clinical and organisational priorities.

Developing a women's friendship group ourselves

The women asked me would I run a women's group for them. The young Aboriginal women's group had finished and the worker had returned to her base in the Western suburbs. The need to meet in a supportive environment had not diminished and their conflicts with the Aboriginal Neighbourhood House seemed to be escalating rather than resolving. After my last round of discussions with stakeholders, I too felt there were few other options left. In the interests of true reciprocity, as well as the increasing despair and sadness that I detected, I agreed to support them in their vision of a women's group, with a suggestion that rather than me facilitating the group *for* them (as I had in 2003 for the family well being program), we would *work together* to develop a group using PAR processes. I identified that I could only commit for the rest of the year (early to late 2006) and so part of our planning would need to include what would happen the following year. I was mindful of E Stringer's advice per telephone on 6 February 2006 that *when ever I am going into a project, I am thinking about how I am going to get out of it at the end*. I was also aware of the importance of not promising anything that I could not actually provide (National Health and Medical Research Council 2003). The women agreed that to co- develop a group was agreeable.

My role in the development of the women's friendship group became one of pragmatic support person and the link to the health staff on the campus. The co- researchers and I brainstormed and recorded ideas on butcher's paper³⁷. I asked the six trigger questions of who, what, how, why, when and where as suggested by Stringer (2007). We discussed who would be involved, would it be an open or closed group, when and where would it be held, on campus or

37 Co-planning action– building a pragmatic vision

off campus and if on campus, in which building? We explored our motivations, why were we doing this? Was it because of a lack of services (negative focus) or because we wished to create a space of friendship and sharing (positive focus). The concept of positive collaborative action changed the energy in the room, bringing with it feelings of hope, possibilities and well-being.

The women envisioned a group similar to the Aboriginal young mum's group of 1999, but with a greater emphasis on friendship. It would be open to women of all cultures, rather than Aboriginal women only, because their friendships extended beyond the Aboriginal community. In many ways it reflected the kind of group that may have developed within the NE Neighbourhood House, had it remained on campus.

Originally the women envisioned;

If we could have an Aboriginal health worker 5-10 hours per week, a budget that the group could work with, lunch supplied, transport to and from the campus, the use of a room every week to create a women's space, and guest speakers to talk about health, arts, and general knowledge (AWG D5).

However, being pragmatic, we also discussed the very minimum that we needed to run a group, as we had limited resources or organisational support. We agreed that we needed an available space where everyone could feel comfortable and welcome. The women's preference was the mainstream community health building³⁸. One of the Aboriginal health staff said she could possibly support the group but could not make a firm commitment due to increasing workload and management changes. I possibly had a small primary health care research bursary coming. We trimmed down the minimum to be *a room, a small budget, community women and support from Janet (AWG D5)*. The women felt the budget needed to cover lunch and craft items as many of them were in tight financial situations and could not afford to buy these items themselves. Most walked to the campus with their children or caught the bus, only one owned a car. We could manage without childcare support as most of

³⁸ We discussed the possibility of holding the group off site, at another venue or in someone's home, but that was not a workable option for most of the women. They preferred the known and neutral space of Community Health.

the children were in kindergarten or school. The few other young children could come in and be part of the group. As one woman put it, *they will be community kids* (AWG D5).

My negotiation role between co-researchers and stakeholders

During the planning phase, I increasingly took on the role of negotiator. The women asked if I would talk to staff and managers on their behalf and in view of the past relationships and dynamics, I agreed. Over the next few weeks I began a third round of discussions with local stakeholders. The community health service staff were supportive of the idea of the women's group as long as there was management support and the Aboriginal Neighbourhood House did not perceive that the group was jeopardising existing programs and working against them. The manager expressed relief that something positive was happening for these women at last. It was generally agreed that we could meet in the Community Health group room on Mondays, and that the group was related more to my/our research than to health service provision.

The current manager at the Aboriginal Outreach Health Service (AOHS) was concerned that the Monday group would take women away from the diabetes group that had just commenced every second Monday. We negotiated that the women's group could possibly start later every second week to enable the women to continue attending the diabetes group. I began to wonder who 'owned' the Aboriginal community women. Managers higher up in Aboriginal health reissued their warning about being careful about the kind of group I embarked on, in view of past actions. I reinforced that this friendship group was filling a gap while other services were being developed. This arrangement seemed acceptable for stakeholders.

I received a Primary Health Care Bursary toward providing Aboriginal women's health days at the campus. These were progressing with limited success due to the fact that the Aboriginal health services were still being established and management and staff turn over was high. I was able to negotiate that a portion of the bursary could be re-channeled into supporting the women's group activities by arguing that many of the Aboriginal women valued ongoing weekly sessions over one off events. Meanwhile, the women

spoke with other women in their community networks and asked what they would like from a women's friendship group.

The group begins

In term two of 2006 the Women's Friendship Group began³⁹. The Aboriginal women co-researchers invited women they knew through the Primary School, gardening group and Gilles Plains Community Campus. We began meeting on Monday's and over the next six months between three to ten people attended each week. There was a core group of the four Aboriginal women co-researchers, five other Aboriginal women who attended from time to time depending on other priorities and transport availability, a family of Maori women, and two Non-Aboriginal community women, and me.

Our first group activity was strengthening the collective vision of how the group would run. A group agreement was discussed and written on butcher's paper. The women envisioned a flexible, casual atmosphere, where people *felt safe and supported; a space to meet, relax, talk, do craft together, to just be, to leave feeling better than when you arrived* (WFG M1). A place where *women's own knowledge is valued, not just outside expert knowledge* (WFG M1).

We drafted a \$1000 budget on butcher's paper, allocating money for catering, arts, crafts and transport. The women decided to have monthly meetings to review how the group was going, based on the community health gardening group that functioned well as a grass roots program⁴⁰. We also discussed having a negotiation rather than conflict intention (concepts from Family Well-being) and that we would try to work in with other services on campus rather than compete with them. For example, some participants did wish to attend the Aboriginal diabetes group held fortnightly at the same time, so we structured the group around those times. Two of the women who attended said that they had *never attended a group before, outside of family meetings* (WFG M1) and that they found the negotiations involved in setting up a group very interesting.

39 *Taking action - the group begins*

⁴⁰ The women had enjoyed attending the Friday community gardening group but now the times clashed with the Friday Nunga lunch at the Aboriginal Outreach Health Service.

From a community nurse /researcher perspective, creating this group was a multi layered negotiation and capacity building exercise.

Co-researcher evaluation of the women's friendship group

During our monthly meetings we reflected on how the group was going, whether it was meeting everyone's needs, and if so how and why? If not, what else could we do? The women discussed that coming to the group was helping them to deal more effectively with the complex personal, family and community issues in their lives, such as;

financial and legal concerns, housing issues, domestic violence, mental health concerns, caring for someone else with a mental or physical illness, alcohol and dependence, raising their own and extended family children, children being in trouble with the law, lack of transport, illnesses, isolation, discrimination, grief and loss, and too many funerals (WFG M2).

Most of the women said that they found it useful to informally discuss their lives with others in the group, who offered suggestions, strategies and support. When appropriate I also suggested possible referrals to services and agencies.

Both Aboriginal and non-Aboriginal women experience difficulties

Both Aboriginal and non-Aboriginal women spoke about issues related to socioeconomic situations, unemployment, violence, disability and parenting children and teenagers and accessing services, reinforcing the concept within postcolonial feminism (Browne et al 2005; McConaghy 2000) that complex and multiple issues impact on Aboriginal and non-Aboriginal women's lives beyond racial differences. After identifying that many women had financial concerns, we invited a financial counsellor to come each week to speak with the women and then see them one on one in a confidential office to work through outstanding bills, child and family payments.⁴¹ The women reflected that addressing financial concerns was a major benefit to their mental health and well-being. They also identified that *being encouraged and trusted to make*

⁴¹ We met the financial counsellor on campus. She was coming to attend the Aboriginal Neighbourhood House, but her hours clashed with the diabetes group, so she spent a term working with the women in the women's friendship group instead.

decisions and have equal say in the budget and expenditure of group funds was incredibly important for them (WFG M2).

The significance of a supportive group

The women discussed how attending the group enabled them to cope with the everyday issues in their lives, and to prioritise their own health and well-being. Toward the end of the year one of the women had a pap smear after a twenty two year gap since her last screening. She said that what was important for her was that she had the freedom to seek screening when she was mentally, emotionally, physically and spiritually ready, and that she could go to the provider of her choice. We all supported her but no one pushed her. One day she came in and asked me to do her pap smear, and so I did.

Another woman found that the group enabled her to cope with the difficult situations she was dealing with as a parent of teenage child who was in difficulties. I refer to my reflective journal.

One of the women came into the women's group this morning saying that over the weekend her child was at an incident that involved the police. She had been worried about her child's activities for months and had been trying to get help, with little success. She asked if she could use the phone in the group room to try to arrange assistance for her child. There were only a few of us at group today and we quietly went on with craft work while she made the calls to police and youth services, and to her family. In between calls she came over and talked with us, we made her hot drinks, and then she went back and made more calls. By lunch time she looked flat and drained and said she had done as much as she could. We ate lunch together and talked about what we would like to do for the afternoon. We decided today would be a good day to go out and purchase material for sewing (we had allocated this on our group budget). We all got in my car and went to a nearby store. We had timed it well, as there was a massive sale with many ends of rolls of materials. We wandered around selecting huge amounts of material for very cheap prices. On the way back in the car we talked about what we would make; children's bedroom curtains,

bedcovers, cushions, kitchen window curtains etc. We returned to the campus and stored all the material in the store room. The woman who had had such a difficult morning thanked us, saying that the afternoon had been heaps of fun and that doing *retail therapy* together and dreaming of what we would make helped her feel balanced enough to go home and care for her younger children.

(Reflective journal p 36 – date withheld as requested⁴²)

This account highlights the pragmatic ways that the women supported each other through difficult times. Another woman who was the sole carer for three children reflected that *when I am at the group I can be softer, whereas when I am with the kids I have to be harder and stronger. Here I can just be me.* Another woman agreed, saying *we pick up our roles and our stresses when we walk back out the door.* A third said that she *takes the friendship and warmth and it stays with her for the rest of the day.* A fourth woman identified that *we can tell each other things here, it is like therapy and networking in a really relaxed, safe and stress free way* (WFG M3). On many occasions women shared their challenges and celebrations related to child rearing.

Acceptance, belonging and friendship

Collectively the women indicated a sense of belonging and acceptance, being liked for who they are, being able to talk freely without having to watch what they said while in the group. Some of the Aboriginal women said that this balanced the difficult things about being Aboriginal women which they described as *colonisation effects, discrimination and all the shit that comes with being Aboriginal* (WFG M3). We discussed the effects of discrimination on their lives. One woman said *I don't think I encounter much discrimination...except when I go into a shop and every one ignores me, looks the other way and won't serve me.* She thought quietly for a while and then said *actually yes, I do face a lot of discrimination at first until people get to know me for who I am.*

⁴² In the small tight knit community dates and other details can identify easily the person involved.

One Aboriginal woman wrote her evaluation into a poem and has given permission for me to include it in this thesis.

Everyday life of a woman

*Our lives can be very stressful sometimes,
Sometimes there's not enough time in the day
Sometimes you feel like you're being pulled in all these different
directions
Sometimes it's hard to keep that smile on your face
We need to keep our feet planted in the ground
We need to have balance in our home and life
We need to be able to recharge our batteries so we can do it all over
again.
It's good to be a part of something
It's good to be able to put your guard down
It's good to relax
It's good to share
It's good to laugh
It's good to cry
I feel I'm not on my own
I feel I belong to a group of women who sometimes feel like I do.*

Another Aboriginal woman also indicated that she valued the group because it enabled her to broaden her friendship circle. As a child, she was encouraged by her mother not to move beyond the family for friendship, not to tell people about her Aboriginality, but rather protect herself from discrimination and ridicule by remaining within the family sphere keeping her cultural background secret. As an adult she still found it difficult to make new friends, but said that the women's friendship group had provided a safe space to practice doing so. Being an open group, embedded in Aboriginal women's preferred ways of interacting, and made the group a safe space for her. One woman said that the Women's Friendship Group was a mini reconciliation project, similar to the community garden reconciliation project at Gilles Plains.

A safe space to discuss changes and options

The group also became a safe space for the women to talk about changes to health services on the campus. Together we discussed the health system structure, that the Aboriginal health service has a regional as well as local mandate, and the effect of state and federal government policies. We began to draw similarities and differences between the ways different services were

provided, and the reasons why this might be. One realisation was that the mainstream community health service had been on site at Gilles Plains for many years, whereas the Aboriginal health service was still a very new and developing organisation. The community health service had a multidisciplinary focus with outreach staff being relatively equal decision makers with minimal management supervision (following a comprehensive primary health care model) and no doctor, whereas the newly developing Aboriginal health service had a definite clinical, medical and management hierarchy (primary care), with little decision making by those most closely in contact with women. The high turn over of staff and management alongside state government and health sector changes created ongoing change and confusion for staff and community members alike.

Strategic Planning – exploring future options

An important aspect of our collaborative research involved strategic planning of ‘where to from here’. I was only able to commit to working alongside the community women for a year. The women identified that they did not want to run a group themselves, saying they did not have the inclination or energy to do this. Those who were feeling motivated were funnelling their energy into other areas such as looking after children or family members, or seeking training and employment. Others were struggling with major issues that left them no energy for such tasks. In group discussion the women adapted the original options to:

Option 1 – connect with services at the Gilles Plains campus.

Option 2 – seek activities and support off campus.

Option 3 – continue with the Women’s Friendship Group.

Option 1 Connecting with a wider range of services at the Gilles Plains campus.

Members of the Women’s Friendship Group became actively involved in collaborative activities at the campus, leading to improved relationships. These included making Nunga cushions for the campus crèche, catering for the after school hours Aboriginal homework program and assisting at the Aboriginal women’s health days. During all of these activities, we quietly built and rebuilt relationships between Aboriginal women and service providers. A range of

programs were planned for the following year at the Aboriginal Outreach Health Service including Tai Chi, computer programs, women's counselling and support and Nunga Lunches. A six week sexual health course was being run and two of the women were attending. The Campus Gardening Group was another option.

Option 2 Seeking additional services off campus

An ongoing issue for the women related to parenting teenage and pre-teen children and grandchildren. We began to search for options off campus, as the campus now had a focus on preschool (under 5 year old) children and their parents. A parenting pre-teenage children course was available at a nearby community centre and the women decided to attend as a group. They found the course useful to varying degrees, and invited a facilitator to come to Gilles Plains the following year. An unexpected benefit was that the women learned of programs that they could attend at this and other sites, and attended an Aboriginal specific mothers group in another nearby suburb with transport provided by group facilitators.

Option 3 Continuing or discontinue the women's friendship group

Toward the end of 2007, the women decided to close the Women's Friendship Group and see if they could find suitable meeting places in other activities and groups held on and off campus. The general feeling was that the Women's Friendship Group had filled and healed a very large hole, and now the women were ready to move on to other activities. The Aboriginal Outreach Health Service had continued developing, and with the programs on offer, the women felt they would have a space where they belonged.

Co-presenting our findings at conferences

An important aspect of ethical community based Aboriginal health research is ensuring that the findings are jointly owned and shared and distributed by and with community co-researchers (National Health and Medical Research Council 2003; Stringer 2007) When I first suggested to the women co-researchers that we could co-present our individual and collective knowledges at upcoming conferences and workshops they were unsure, saying *none of us*

have been involved in public speaking or education beyond basic secondary schooling. However, they agreed to consider it. I asked the women what they most would like others to know about our work together. They replied;

Services need to be friendly, build trust, listen to community members, value what community say and have longer term projects.

It is really off putting when people are too busy and ignore you unless you go up and say hello to them first (FG D4)

They spoke of the importance of relationships, time, trust and respect. We began jotting ideas on butchers paper and came up with the equation **Time + Respect = Trust**. This became the basis of our presentations (see for example Appendix 11). The women stressed the importance of spending enough time and energy building respectful relationships in health care and research because from their perspective without trust there was no real engagement, and no lasting improvement in Aboriginal women's health.

I recorded all of these ideas and began writing them into power point presentations. Each week I brought concepts from Aboriginal Health Research Ethics, collaborative research and participatory action research and together we worked out how these related to the women's knowledge. This two-way Ganma knowledge sharing process provided further analyses that have informed this chapter. I also brought ideas from the Elder women in the Aboriginal Women's Reference Group, and so our discussions and co-writing became a link between the different groups of co-researchers and stakeholders.

There were two relevant conferences being held in Adelaide; the International Inequities in Health Conference (ISEqH), and the PHCRed Primary Health Care Conference. I obtained a sponsored ticket to the ISEqH conference which enabled three community women to attend on different days. The women decided among themselves who felt most able to co-present at both events. The practicalities of enabling a co-presenter to attend the first conference were very involved. While such detail is often not discussed, the women and Aboriginal mentors asked this information to be included as it made the difference between Aboriginal women being involved or not.

The practicalities of successful co-presenting

The co-researchers have given me permission to use their names in this account as their involvement is already publicly known in conference abstracts. The following is an excerpt from my journal.

Our presentation at the ISEqH conference was scheduled for late morning. I arrived early at (school drop off time) at Gilles Plains to meet Rose who was to co-present with me. When she arrived she said that she was not able to come as there was a sick child in the family that needed to be taken to hospital. Having a woman centred approach enabled me to understand, support and respect her priorities and ensure that her family had transport available (they did). I then turned to another of the women and asked if she were available to co-present. We had all co-written the information, so it was known to all of us. She said that she herself had a medical appointment for one of her children and could not attend, but suggested we try Jo who should be dropping her child off at kindy about now.

We went across to the kindergarten and met up with Jo who said she could come, but she needed to go home and first. She asked that I come back and meet her later, and could we be back in time to pick up her daughter from kindergarten. Her youngest daughter would be with us. I thanked her and agreed with all of her suggestions.

I met Jo and her daughter as planned and went in to the conference which was being held at a city university. On the way in we decided who would say which bits of the presentation. We settled in, listened to a few presentations and then went up to prepare. We negotiated to speak first rather than third in our session, so that we could get back to Kindy in time. We all three went up onto the stage area explaining to the audience that Rose could not attend, and that Jo had stepped in at the last minute. Jo's daughter sat in the lectern at our feet and from time to time added her own comments to the presentation, all of which was easily heard by the audience. For example, when Jo was emphasising the importance of close relationships by saying '*Janet is one of us*'. Her daughter tugged her pants and said 'but no mum she's

not, she's not Nunga'. Everyone laughed and it added another dimension to the presentation. At the end of our presentation Jo's daughter needed the toilet (*quick mum, I gotta go now*) Using the advantage of the microphone we asked where the nearest toilets were.

The verbal and non-verbal feedback we received during and after the presentation was very positive. There was an international as well as national and local audience. Jo was a natural public speaker, speaking from her heart, and blending presenting and mothering effortlessly. I am in awe of her skills (reflective journal – ISEqH07).

This account reflects what is possible when extra time and care is taken.

In this section I discuss Aboriginal co-researchers and my experiences, conversations and realisations during and following the conferences. I do this to highlight particular aspects of privilege and exclusion. I have purposefully written myself into this section to highlight how Ganma knowledge sharing enabled us to reach new understandings.

The significance of being heard and acknowledged

On the way back out to Gilles Plains Jo and I discussed our experience of co-presenting. Jo said;

That Maori woman in the front row, she was nodding her head off. She knew what we were talking about. There was a silence and then she said it is not just us, is it. Not just us Aboriginal people, it is the same for all Indigenous peoples around the world. We all experience the same thing.

We discussed that by attending and presenting at the international conference, Jo had had an opportunity to place colonisation into an international context.

She then said *and people sat there and listened to us, for fifteen minutes. And then they nodded and clapped. Silence, then That doesn't happen very often in my world.*

This was a profound moment for me. Suddenly I understood the benefits and privilege of being a white woman, a nurse, a person who can take for granted the opportunities to present at such forums and have your knowledge publicly accepted as being legitimate.

Jo also said *there are other people out there who care; we thought it was only you.*

This comment highlighted for me the position that many Aboriginal women hold within our society. Although I know for a fact that many people do care, this was not obvious for Jo.

And then she reflected; *there are other ways to get your point of view across. Other powerful ways, not just anger and conflict.*

We discussed our learning in the Family Well-being course, about moving from conflict to negotiation, to spirit centred approaches. Our collaborative activity had enabled Jo to experience this in new ways.

Many of Jo's comments were reinforced by the other two women who attended the conference during the next two days. They too noted that there were similar experiences for Indigenous peoples internationally, that there were many other people around the nation and world who did care about others, and that there are very powerful and non conflicting ways to get one's point of view across.

Time + Respect = Trust

Rose had psyched herself up to co-present and asked if she could co-present at the next conference. The group all agreed, and she came with me to the Primary Health Care Conference. Once again we negotiated the timing of our presentation to enable us to get back in time to pick up children from school. Rose was nervous at first, but once she began talking, she spoke powerfully from the heart. Together we spoke of time, respect and trust, using our own relationship as an example (rather than talking negatively of campus events). Once again I refer to my journal.

When Rose began to talk from the heart, she spoke about the importance of relationships between people. We shared our relationship building journey with the audience, allowing them to understand the years of work that we had both put into our now very positive relationship. Rose then said that while some relationships build up over time, sometimes people also have an immediate liking or disliking for someone. She explained the importance of this in health care – that

sometimes Aboriginal people will dislike or distrust someone immediately. There is something that they pick up, a feeling, or vibe that puts them on guard. It takes a long time to get past that initial feeling (Journal notes September 06).

Once again, on the way back in the car, Rose reflected on how positive the experience was, that it was *scary, challenging and nerve racking, but also incredibly empowering* (Journal notes September 06). She noted that people had listened intently, and this was a powerful experience for her. She offered to come and co-present again if the opportunity arose. Mentally I reminded myself not to doubt community women's strength and abilities.

In the following weeks, I shared with stakeholders on the campus how powerfully the community women had presented, and how well they had been received. This challenged entrenched viewpoints that some stakeholders held about some of the women. The conferences were internationally and nationally respected and to speak at them involved particular skills and recognition; that the women were involved as co-authors and co-presenters required people to view them in a new light. I came to understand our co-writing and co-presentations as a decolonising and postcolonial transformation strategy (Ashcroft 2001b; Said 1993). We had used colonial systems and hierarchies in ways that levelled the playing field, created opportunities for those often marginalised and challenged mainstream assumptions.

In mid 2007, Rose and I again co presented at the National Action Learning and Action Research conference at Tauondi College that I co-created with another group of co-researchers (Collaboration Area Four). The experiences of Rose, Jo and the other community women heavily influenced my decision to co-develop a culturally safe and respectful space where Aboriginal peoples knowledges and preferred ways of knowing and doing could be recognised. One of the staff members from Aboriginal health assisted and supported Rose to get to the conference. Once again Rose was very nervous, and yet she spoke from the heart. People have since told me that her words, and the way we presented together, impacted greatly on them. At the time of re-writing this paragraph (June 2008) I have just presented my research findings at a General Practice and Primary Health Care Conference in Hobart. I realised that my

(very well received) presentation style incorporated the passion and ‘from the heart’ approach that I learned working alongside Jo and Rose. Gamma two-way knowledge sharing and capacity building for both nurse researcher and community co-researchers is made possible through PAR. Everyone benefits from democratic collaborative processes as suggested by Freire in the discussion of Dialogical Education in Chapter Two.

The significance of this research for those involved

Co-researcher reflections⁴³

In late 2007, I invited the four Aboriginal women co-researchers to reflect on what our collaborative research had meant for them. The women described the Women’s Friendship Group as a *healing space* where they had *felt heard, valued and acknowledged*. It was also *safe space* where they could *talk about what was bothering them and think things through*, as well as *focus on strengths and abilities, hope and celebrations*. They *felt welcomed, like we belonged*. They said that *the way we all made decisions together in the group as well as supporting each other to make decisions in our own lives* had enabled them to *heal enough, and trust enough to attend other health services*, including Aboriginal health services (AWG R1).

Some of the women looked back and saw that our time and activities together had given them the additional tools and confidence they needed to take the next step toward significant changes in their own lives. The women identified my role of nurse/researcher/facilitator as being someone who had *the time, inclination and ability* to listen to and work with them. I was seen as a *friendly communication person, a link between community and the changing and developing health services*. Most important for some, was that *that they knew that I was someone who cared*. At the end of our collaboration activities, the four core women went in different directions. One left a violent partner and began employment for the first time in many years. Another moved to a different part of Adelaide to make a new start with her children. The other two women remained connected with the campus and attended a women’s group,

⁴³ This section privileges co-researcher perceptions, and is purposefully placed before my interpretation and discussion of the findings.

Tai Chi classes, mental health support and craft activities as they became available at the Aboriginal Outreach Health Service (AOHS). One unexpected outcome was that two of the women became involved in another Aboriginal health research project. Having co planned, co written, co presented and co-distributed our research and our findings, they said that they *felt comfortable and knowledgeable* of the processes involved. In view of the negative connotations associated with research in post-colonial Australia (National Health and Medical Research Council 2003; O'Donnell 2006b), this is a very significant outcome.

Stakeholder reflections

I also spoke to stakeholders (Aboriginal health workers, managers, nurses, doctors, receptionists) at the Aboriginal Outreach Health Service in late 2007, inviting them to comment from their perspective on the impact of the community women and my collaboration. Some said that *it was good that there was somewhere for the women to go while we got things sorted out here, we were not able to provide what they wanted* (CA1 SR1)⁴⁴. Others suggested that the PAR activities had helped *to keep the women out of our hair*. A deeper analysis from an Aboriginal Outreach Health Service perspective is provided in the next chapter.

When I spoke with Gilles Plains Community Health Service staff members in late 2007, two indicated that they had *felt uncomfortable with the gap in service provision that had emerged and with what happened to the community women as a result of it*, but had *felt powerless to do anything*. They were relieved that the *participatory action research occurred, helped to provide a safe space, a sounding board and a healing space for the community women* (CA1 SR2).

A quote from one of the longer term staff members of community health reflects a deep stakeholder perception of what was occurring at the campus throughout this research project. They said;

I recognise the struggle to stay engaged with communities we are working with because we have, time and again, let people down. And that is

⁴⁴ Collaboration Area 1, Stakeholder Reflections 1

something that we can't pretend hasn't happened. There have been expectations set up, whether they were unrealistic or set up by someone who then left, or they just never came to fruition. When you disappoint people like that, they tend to stand back. I think we have a lot of ground to cover here. Although we have a rich history of working well with community and they have shared things about what needs to happen for them, we have this other past as well, that means that we are always needing to nurture and maintain the relationships we have got. You can't just take it for granted. ... I am really frustrated about people not really understanding that if we don't take the steps that are required we won't achieve. There are no short cuts. We might be able to sign something off as being resolved or shift a problem to another place, but we have learned over the years, that working with particular individuals over time, is really critical (CA1 SR2).

This long term staff member indicated that there are many difficulties in trying to maintain relationships with Aboriginal community members amongst unmet expectations, changing approaches to health care, and a health system that focused on outcomes rather than processes. However, she felt it was *imperative that we keep trying*.

My reflections as nurse/researcher/facilitator

Working alongside Aboriginal community women in this research assisted me to view the health system from a community perspective. I was reminded that health service provision is as much about relationships and communication, as it is about the kind of health services that are provided. I realised that as a health professional and organisational employee, I had become enculturated to seeing things in a certain way and many practices and inequities had become invisible to me. I found that working collaboratively with the women in this research enabled me to participate in community development and empowering activities, in ways that I was finding increasingly difficult to do within our current health system. Changes toward mainstream and standardised selective primary health care and a move away from Women's Health and Aboriginal Health programs was leaving limited opportunities for client centred community development in primary health care. During this research,

Ethical issues related to my positioning as *nurse/researcher/facilitator* arose at particular times. For example, being told about the proposed name change for the Aboriginal Neighbourhood House and being expected not to share this information with the community women I was working collaboratively with. My decision not to remain silent, and yet not pass on the entire information either, was met with mixed response by both health professional peers and community women. Over time however, my position of relative neutrality and focusing on win- win outcomes was respected by co-researchers and stakeholders alike.

Themes and discussion

In this section I discuss the findings from this Collaboration Area under the three central themes of knowledge sharing, working together and addressing issues. Although these themes and the findings do not fit neatly together (there is some overlap), this format provides a basic structure for this discussion.

Knowledge sharing

This Collaboration Area has focused on the perspectives of four Aboriginal community women who were seeking women-centered holistic health care at the Gilles Plains Community Centre. Prior to 2002, these women had previously been involved in, and enjoyed, comprehensive primary health care programs embedded in democratic and two way knowledge sharing (Ganma), shared decision making and collaborative planning. The women discussed that they preferred health programs because they *addressed a wide range of health and well-being issues, were welcoming, provided friendship and companionship and helped to develop skills they needed for life and work*. In addition, such programs helped to counter the daily effects of colonisation, racism and discrimination. One of the co-researchers explained that *in these programs (Aboriginal Mothers' Group, Family Well Being, Gardening Group) I feel like I belong, that I matter, I have a voice, and people care*. She described programs based in effective and respectful two way communication as *healing and necessary* for her health and well being. She, and the other Aboriginal women co-researchers, said that being heard was one of the most important aspects they considered when accessing health care and well being programs.

The need for Dadirri deep listening

The need for deep and respectful listening in health care and research was also highlighted by the Aboriginal Women's Reference Group, Aboriginal mentors and co-researchers. During community consultations, they advised the need to first sit and listen before suggesting or attempting health or research strategies. They advised health professionals and researchers to listen with their heart as well as their head, to connect deeply, and avoid making assumptions about what Aboriginal people want and need. Deep listening and *being with* the women co-researchers became an integral part of this research process. As described by Atkinson (2002) this enabled me to hear the Aboriginal women's underlying confusion, pain and concerns. Only then could I really understand what was happening for them amidst the changes in health care provision and daily life events.

Very few people at the Gilles Plains Community Campus were in a position to practice deep and non-judgmental listening with the Aboriginal community women at Gilles Plains. With the closing of the Aboriginal Young Mothers Group, opportunities for deep and respectful listening and health and well being support through comprehensive primary health care had diminished. In addition, most of the health professionals with whom the women had developed deep and trustworthy relationships moved to other sites. Those that remained became involved in other priorities and programs. With the changing focus from supporting Aboriginal women to supporting new arrival refugees, and parents with children less than five years of age, support for these Aboriginal women who had primary and secondary aged school children in their care, decreased. Relationships between these four community women and incoming health professionals at the Aboriginal health service were tenuous at best. Unmet expectations, differing priorities and busy workloads interfered with effective communication. Most of the other Aboriginal community women no longer visited the campus as a direct result of reduced services and transport support. Keeping in touch was difficult due to poor transport across suburbs, and non- functioning home telephones. This left the four Aboriginal community women with few support networks at a time that they were experiencing very complex issues related to parenting

teenage children, challenging financial situations, repeated experiences of loss and grief, housing and transport concerns, violence in the home and/ or unemployment issues. Although they identified the need to discuss these issues and seek support and assistance, they did not know where they could go to seek culturally safe care.

We began working together in this research by spending considerable time discussing concerns and issues (*look and listen, think and discuss*). I listened deeply and respectfully, and acknowledged the women's concerns and priorities by writing them onto butcher's paper. Only after all of the women's concerns were recorded, did we begin to discuss ways to *transform* the situation, to step out of the current situation and create something new (Ashcroft 2001b). We revisited our joint learning from the Family Well Being Course, focusing on ways of moving from conflict to negotiation. Together we practiced respectful two-way knowledge sharing and deep listening with each other, and then with a wider circle of people, including health professionals across the campus. Taking small pragmatic steps, we endeavoured to heal relationships and begin respectful dialogue and collaboration with health care providers.

Working together

The necessity for healing in health care

The potential for healing through collaborative approaches in postcolonial Australia is important to acknowledge. Aboriginal women co-researchers named collaborative health care and research activities as *healing*; a time of *rebuilding trust and relationships, re-connecting with health services in positive and more equal ways*, while also *being supported* to deal with the difficult aspects of complex lives. The women identified the need to heal personally, and in relation to other people, through improved relationships. Similarly Atkinson (2002) described healing and decolonisation as slow and gradual processes, that are vitally important for improved health and well-being of Aboriginal people in Australia today. They are needed to counter the personal and intergenerational negative effects of colonisation, exclusion and

discrimination that affect the health and well being and health seeking behaviour of many Aboriginal women.

The need for respectful two way relationships and healing in health care encounters can be easily overlooked by health professionals, managers, policies and health system structures, particularly when other aspects of care are prioritised. For example, selective primary care programs that focus on improving physical health issues may over look the importance of building positive and trustworthy relationships with clients. Without improved interpersonal relationships between health professionals and Aboriginal clients, the health care program may not be interpreted as culturally or personally safe. The Aboriginal women in this Collaboration Area specifically identified the need for health professionals to take the time to build respectful relationships with them in order for them to trust enough to attend programs and services. When co-writing a conference presentation about this issue the women and I summarised this concept as Time + Respect = Trust.

The importance of friendliness and friendship

Similarly the Aboriginal women co-researchers stressed the importance of friendliness and friendships in postcolonial Australia. They discussed that when meeting new health professionals, they sought signs of friendliness and approachability before opening themselves to a client-professional relationship. If the health professional *hid* most of their personality behind a *cloak of professionalism*, and were *unreadable*, they found this very off putting and chose carefully what they would or would not disclose. *Friendliness* became a benchmark to determine if the health professional was someone they could form a trustworthy relationship with. They did not expect health professionals to become *friends* (although this did sometimes occur); but they did seek reassuring signs of *friendliness* for true engagement. One woman related that for her, the need for such relationships stemmed from past experiences of children being taken away in the Stolen Generation. She inherently distrusted health and education professionals until she had built positive relationships with them. This became obvious in the parenting courses and the discussions the women had afterwards. Until the worker was deemed to be safe (i.e. that

they would not take the children away), parenting issues could not be openly discussed.

The importance of friendships with both Aboriginal and non-Aboriginal community women was another aspect discussed through the Women's Friendship Group. The Aboriginal women co-researchers highlighted that making friends was not an easy or smooth process that they took for granted because racism, discrimination or past experiences got in the way. For example, one of the women discussed that as a child she had few opportunities to develop friendships outside of her family connections because her mother had encouraged her to confine friendships to family and not identify herself as Aboriginal in order to avoid racism and ridicule. As an adult, she still found it difficult to make new friends. She indicated that the Women's Friendship Group provided personally and culturally safe spaces for her and the other women to develop positive friendships. All four Aboriginal women co-researchers highlighted the importance, and uniqueness of the way the Women's Friendship Group developed with the four Aboriginal women being co-creators. This enabled them to feel comfortable identifying as Aboriginal people and in invite other women to join them in health and well being activities. It was not often that they had opportunities to initiate and co ordinate such women focused reconciliation projects. They enjoyed the freedom to deepen friendships and share their cultural values in positive ways.

Working respectfully with expectations

The process of developing the Women's Friendship Group also provided opportunities for the women's priorities and expectations to be respectfully acknowledged and incorporated into a developing health program. The Aboriginal women held the Aboriginal Mothers' Group of 200- 2002 as the ideal health program. It was collaborative and had positively addressed the women's comprehensive primary health care needs in culturally safe ways. Unfortunately, it was impossible to recreate this program because the health organisations involved had undergone staffing, policy and funding changes. Rather than dismissing the women's vision however, I sought to identify with the women what they most valued most from their experiences in that group (*look and listen*), and work with them to find creative ways to include these

aspects in future collaborative programs, with the few resources available to us (*think and discuss*).

The women originally envisioned a well run, well resourced comprehensive primary health care program with transport, catering, childcare and craft materials supplied. We compiled a list of what would be needed for this to occur. We then identified the health professional support, funds and resources that were immediately available to us. Comparing the two lists, we made pragmatic decisions together about the very basics we needed to run a group. These became; a room, a group of women, someone to help facilitate the process (me) and preferably a small amount of money to pay for catering, craft items, and transport if needed. The women decided they could do without childcare support by bringing any children into the group and caring for them together.

This collaborative process enabled everyone's knowledges to be included and swirl together in Ganma knowledge sharing processes, creating new knowledge (foam) about how to begin a women's group with minimal resources. We focused on what was available and what we could create, rather than on what we didn't have. Very democratic decision making processes were embraced, with the butcher's paper becoming an acknowledgement and decision making tool. Our processes were similar to those described by Belenky and colleagues (1973) as Midwife and Connected teaching. The women's own thought were supported and nurtured to maturity with understanding that uncertainty was part of the process. I was able to hold both a subjective and objective position, encouraging the women to trust their own thinking and embrace community as well as health system resources. This enabled us to address issues in new and creative ways. Even though we could not develop exactly the kind of program the women originally envisioned, the collaborative process of working it out together meant that the resulting program could still meet their most pressing needs. The women felt this was an important achievement within in the passing parade of health care.

Addressing issues

Like a kangaroo sitting and watching the passing parade of health care

The Aboriginal women discussed their experiences of seeking, and being involved in, a diverse and constantly changing range of health care programs and services at the Gilles Plains Community Campus over the previous five, ten and twenty years. The women had seen many policies, programs and health professionals come and go, some of which they judged as being more useful than others. The Aboriginal women had remained in place while the health system swirled and changed around them. This situation challenges the commonly held view that *Aboriginal people are transient and the health system is stable*. The Aboriginal women discussed being positioned *like a kangaroo watching the passing parade* of health care, policies, practices and professionals. Sometimes they sat back and watched what was happening, like a kangaroo sits on the edge of the scrub, watching, waiting and judging if or when it was safe to become involved. At other times they chose to actively participate in programs, particularly holistic programs focusing social and emotional, physical and mental health and well being such as the Aboriginal Mum's Group, the Gardening Group⁴⁵ and Family Well Being. Unfortunately their experience was that just when they were *getting comfortable in a program*, it stopped, or the staff members changed, and they had to reconnect and learn to trust all over again.

Some of the women discussed experiencing very deep feelings of loss and anger during health service changes. One woman spoke of continued changes being *like another bag of poisoned flour, rising up our hopes and then dropping them down again*. For her, the link between past colonising experiences and present day practices was very strong. This highlights that while colonisation, exclusion and discrimination is considered old news by mainstream Australia, it is very much part of the living memory that influences Aboriginal people's lives, experiences and decisions today. When working with health professionals in Collaboration Area Two I discovered that they also expressed concern about the constant health system changes and the impact

⁴⁵ The Gilles Plains Gardening Group is one activity that has remained in place as a holistic program for over ten years.

this had on client expectations and experiences. However, they felt powerless to prevent to prevent it happening.

The right to be heard

Critical questions about the Aboriginal women's right to be heard and influence service delivery were raised throughout this research. Although the South Australian government policy documents (Government of South Australia 2003b) state a commitment to community consultations, these community women did not seem to be the community people with whom health services were interested in consulting with. In fact, the women were at times specifically prevented from voicing their opinion or sharing their knowledge, which placed them at a distinct disadvantage. As discussed by Gaventa and Cornwall (2006) the sharing or holding of knowledge is closely linked to power and the ability act. Those in power (in this case the health system) controlled what was considered to be valid knowledge (health system rather than community knowledge) and who could be included or excluded in discussions and decision making through top down decision making processes. This gave those in power (policy makers, funding bodies and managers) the ability to force others (Aboriginal community women) to do what they would not normally do through choice (attend selective rather than comprehensive health programs). With the reduction in comprehensive primary health care and community development programs, opportunities for the women to be heard, in the context of *their* lives, decreased.

To counter this trend of non-collaboration, co-researchers and I focused on collaborative and self empowering activities that enabled the women to recognise, construct and share their own knowledge. Together we viewed the current situation as temporary and alterable, with an underlying belief that the women had the ability to change their own destiny (at least to some degree) by considering choices and options. In a process called dialogical education by Freire (1972), and connected and Midwife teaching by Belenky and colleagues (1973), the women and I explored not only what was, but what could be. Working together we reinforced the women's right to be heard, and challenged the status quo by co-writing and co-presenting at well recognised peer reviewed conferences. Such activities became postcolonial transformations

(Ashcroft 2001b); we quietly stepped out of the expected pattern of who has authority over knowledge, creating opportunities for the women to become recognised experts in their own right. For the women themselves, being acknowledged as people who held significant knowledge that was worthy of sharing became a highly significant turning point.

Culturally safe PAR

The PAR process was a very important aspect of this transformation. Co-creating a culturally safe and inclusive research approach was a positive step forward. Adapting Stringer's (2007) Look, Think and Act to become Look and Listen, Think and Discuss and Take Action, specifically addressed the women's concerns regarding being forgotten and unheard. Using Aboriginal health research ethics (NHMRC 2003) as a guide, we found pragmatic ways to include reciprocity, respect, equality, responsibility, survival and protection and spirit and integrity in the research process. As discussed earlier, supporting and putting into action the women's vision for the Women's Friendship Group, co-writing and co-presenting at well recognised conferences, and actively choosing a range of health care options all enabled the women to be situated as important, recognised and valued.

Summing up

This Collaboration Area has identified important issues related to the provision of culturally safe health care from the perspective of four Aboriginal community women in urban Adelaide. These women's highest priority involved addressing complex issues that they experienced as carers, Aboriginal women struggling with the impact of ongoing colonisation, discrimination and exclusion and lower social determinants of health. In the past they had experienced comprehensive primary health care and community development programs and found that these suited their needs more than selective primary care programs. However, with subsequent health system changes, they felt their preferences and priorities were being ignored. The women sought ways to 'level the playing field' and ensure that their opinions and needs could impact on decisions being made about the kind of services being provided for them. They found the process of collaboratively developing, enacting, evaluating and

sharing with others through PAR very positive and self empowering. It led to the co-creation of women's health programs that could meet their holistic health needs through healing, friendship and personal capacity building. A year later, they identified it as a significant time of healing and growth in their lives.

As an insider/outsider, nurse/researcher using a postcolonial feminist framework, I recognised that both Aboriginal and non-Aboriginal, community and health professional women were placed in complex and ambiguous positions, with differing levels of capacity, resistance and agency at different times and in different situations (Browne et al 2005; McConaghy 2000). Interactions between these local Aboriginal women and Aboriginal and non-Aboriginal health professionals were being influenced by experiences and expectations interacting with, policies, programs and practices. Interwoven with this were past and ongoing colonisation, exclusion and discriminatory practices that influenced the way everyday events. In the next chapter I explore the perspectives and experiences of health professionals at Gilles Plains Community Campus who were trying to provide quality primary health care for Aboriginal women and their families.

Chapter 8 Collaboration Area Two - The Emerging Aboriginal Health Service

Overview

Collaboration Area Two sits alongside and interweaves with Collaboration Area One. It offers insights into the practicalities and difficulties experienced by health staff as they tried to provide health services for Aboriginal women in a newly developing Aboriginal health organisation. This chapter discusses how health professionals and I co-developed and tested our model of collaborative PAR in ways that complemented rather than complicated existing work loads and organisational directives. We began by discussing a broad vision for Aboriginal women's health and well-being (*look and listen*), and then what was possible with the current resources available. Health staff discussed their concerns, challenges and experiences (*think and discuss*) which we then interpreted and analysed. Emerging themes informed the action cycles. Together we planned strategies to address the issues raised. Our collaborative action (*take action*) involved mapping available resources, holding women's health days, and involving local community women and young Aboriginal women in programs. This chapter provides another perspective to many of the issues raised by Aboriginal community women in the Collaboration Area One.

My role in this Collaboration Area was complex and multi-layered. I occupied a position of insider/outsider, being a health colleague who understood many aspects of health care, and yet was not part of the local health organisations and so not bound by the same constraints. I was a researcher who worked with Aboriginal women co-researchers, spoke with managers, and the local health services, and refused to take sides. As in other Collaboration Areas, I considered the process of working together in supportive Participatory Action Research more important than the outcomes, and at times I set the research agenda aside, and focused instead on being supportive, particularly during times of high stress, grief and loss.

Methods

The methods used in this Collaboration Area included community consultations, semi structured interviews and focus groups with trigger questions, and document analysis. There were also less formal discussions face to face, via the telephone or email, and formal meetings such as staff meetings, and meetings between different agencies. These methods were used in repeated and multilayered cycles of PAR. For example, the entire activities in this collaboration followed the pattern of Look and Listen, Think and Discuss and Take Action. I first spoke with, and listened to, co-researchers and stakeholders in interviews and focus groups, analysed and interpreted themes coming from these discussions, and then worked together to develop positive action to better meet the needs of local Aboriginal women. Within this were mini cycles of PAR such as when the co-researchers and stakeholders realised the need for more immediate action, discussed the options and decided to hold a women's health day.

Co-researcher selection

In this Collaboration Area I invited all of the health staff and managers working at/ or being involved with health service provision at Gilles Plains, from both Aboriginal health and community health services over a period of eighteen months. Three nurses, four receptionists, two doctors, ten Aboriginal health workers and four managers became involved voluntarily. All nurses were non-Aboriginal, two receptionists were Aboriginal and two were non-Aboriginal, both doctors were non-Aboriginal, all Aboriginal health workers identified as Aboriginal, and two managers were Aboriginal and two non-Aboriginal. We met together for community consultations, discussions, meetings, interviews, focus groups and PAR activities. Eight chose to become involved in semi structured interviews (five from Aboriginal health, three from community health) and two Aboriginal health workers and one nurse became the core co-researchers in the action phase.

Stakeholder selection

Stakeholders in this Collaboration Area were Aboriginal clients and potential clients of the health service, in particular the women co-researchers from

Collaboration Area One, and young Aboriginal women from Collaboration Area Three. Regional health managers were also positioned as stakeholders who influenced and were influenced by our research.

Negotiated research focus

I initially met with staff and managers as part of the community consultation process and invited their input into the research design and focus. Aboriginal managers asked that I take more than one perspective into view, and that I did not stir up existing conflicts between local Aboriginal community members and the Aboriginal health team. Aboriginal health staff members asked that the research complement rather than complicate their work load as they were already struggling to meet everyday demands. Community health staff and managers asked that I take into account the significant work across the campus in the past and present toward *working with* Aboriginal people. Aboriginal community women from Collaboration Area One asked for an increase in group programs.

Coding of data

It was co-researchers' preference that I use a referencing style that de-identified their positions and cultural background due the need to maintain confidentiality in a small intimate setting where staff members were well known and easily identified. Accordingly I have coded interviews and focus group conversations as AH – Aboriginal Health, CH – Community Health, Hp – Health professional (Aboriginal health worker, community health nurse, midwife, receptionist), Mg –manager, Int – interview, FG – focus group, and D – discussion.

History

The opening of the Gilles Plains Aboriginal Neighbourhood House /Aboriginal Outreach Health Service ⁴⁶ in May 2005 was a highly anticipated and long awaited event. Many events that impacted on the Aboriginal health service occurred before staff members were involved at Gilles Plains Community

⁴⁶ The Aboriginal Neighbourhood House was renamed the Aboriginal Outreach Health Service in 2006 reflecting a change in direction.

Campus. As highlighted in the last chapter, it is worth reviewing them as they impacted greatly on what and how collaboration was possible.

Local Aboriginal community members had lobbied for an Aboriginal Neighbourhood House since the late 1990s, highlighting the fact that there was a lack of Aboriginal specific services in the North East suburbs of Adelaide. Community health staff had worked alongside them in the spirit of community development, capacity building and supporting Aboriginal self determination. An Aboriginal Health Worker conducted a community consultation process and a community vision developed (Gilles Plains Community Health Centre 2004; North East Community Health Advisory Team 1996). In 2003 an older school weatherboard building was vacated and remodelling for the Aboriginal Neighbourhood House began. The building was repaired and office spaces, clinic rooms, one large and three smaller community spaces, and a kitchen and laundry with washing machine and dryer were created. Everyone watched in anticipation. Mainstream community health staff reduced their work with Aboriginal women in anticipation of the Aboriginal health team taking up programs, in particular social and emotional well-being programs and the women's group (Community consultations 2005).

There were many delays in finalising and opening the House and frustration began to build. Aboriginal community members began to wonder if the building and services were being developed to follow someone else's vision (Community consultations 2005). . There was no longer a functioning Aboriginal Reference Group at the Gilles Plains Community Campus. A significant proportion of the Aboriginal Neighbourhood House staff positions became funded through the Medicare linked APHCAP – Aboriginal Primary Health Care Access Program funding which was linked to specific focus on chronic disease management and clinical services. A primary health clinic with a General Practitioner, Aboriginal health worker and diabetes group were the first services to be established. In a health service reshuffle, the social and emotional well-being team who were to provide local programs was moved to another site in the Western suburbs. The Aboriginal health team developed a regional focus and staff members were trained in specific skills that they would use at different sites across the region. Health promotion events such as high

school expos began; bringing school aged young people from across the entire central East/West area of Adelaide to Gilles Plains.

The new look Aboriginal Neighbourhood House was met with a variety of community responses. While most local Aboriginal people agreed that the medical clinic and chronic conditions focus was 'good', they wondered what had happened to their original vision of a community meeting place. When the service name was changed from Aboriginal Neighbourhood House to Aboriginal Outreach Health Service without community consultation, the community surmised that their neighbourhood house was now a government health service, with some community development programs on the side. They watched with mixed feelings as the washing machine and dryer were removed unused, a locked drug cupboard and immunisation fridge were installed, and community group rooms remodelled into staff offices.

One longer term Gilles Plains Community Campus employee who had worked with the original Aboriginal Reference Group and understood the community expectations and hopes, summed up some of the different perspectives and the local impacts she observed and felt. She said;

It is very hard for even us (community health professionals) to follow what is happening with the health service changes. And what the reasoning is behind it.

There is a certain irony of going over to APHCAP funding for the Aboriginal health services which is Medicare funded, based on clinic services and is chronic disease focused.

Finally the local services are Aboriginal controlled, but in the end, because it is linked to APHCAP funding, they are not able to provide what the community wants. There is such irony to it... You cannot argue that there isn't a need for clinical services, because there so obviously is, but how did this all result in moving away from the support of well-being and stress prevention programs (CH Mg Int2).

Most incoming staff members at the newly developing Aboriginal Neighbourhood House/Aboriginal Outreach Health Service had no knowledge of the history behind the service, and found the negative community response very difficult to understand. They were employed to provide a health service,

and they were doing the best that they could with the skills, resources, direction and support available to them.

Upper level (off site) management who were aware of the complex issues, adopted a strategy of providing services within (top down) funding and policy guidelines, while protecting incoming Gilles Plains staff members from community backlash. During the community consultations they said *we don't kid ourselves that we have solved the problem, only smothered the conflict*. Their stipulation in supporting this research was that the research should not further inflame the conflict.

This Collaboration Area highlights the complexities, difficulties and opportunities that exist in health care due to the very diverse expectations, priorities and agendas that community people, staff members, managers and policy makers hold. This situation is not unique to Aboriginal health, but some of the complexities are perhaps more pronounced in Aboriginal health due to the influences and added layers of colonisation, cultural expectations, government scrutiny and multiple funding and accountability streams.

Co-researchers' visions of Aboriginal women's health

Look and Listen – semi structured interviews with trigger questions

I began this research process by inviting health professionals and managers from Aboriginal health and community health at Gilles Plains Community Campus, as well as regional health managers, to be involved in semi structured interviews with trigger questions developed initially through the community consultations and then revised as new themes emerged within PAR cycles. At the beginning of each interview I asked co-researchers to broadly describe their vision for Aboriginal women's health, encouraging them to focus on their own beliefs and ideals before discussing what was happening around them⁴⁷. A diverse range of responses reflected differing perspectives and priorities (and interpretation of the question). Some focused their answers on Aboriginal women themselves, some on the health services and some on wider systems.

⁴⁷ This allowed the discussion to be focused on co-researcher and stakeholders' own knowledge and experiences, following the concepts of midwife and connected teaching of Belenky and colleagues. It encouraged interviewees to tap into their own knowledge and beliefs, rather than immediately discussing the policies of the health system they worked within.

A holistic view of health

All described women's health as something beyond physical health. For example one participant said;

Women's health is much broader than physical health; it involves families, and men and communities. I don't see Aboriginal women's health as a discrete issue, it is very integrated. I guess I see a coordinated approach, integrated and community based, and perhaps also clinical, but in a more holistic way that takes in social and cultural aspects. People having functioning bodies and functioning communities, and feeling connected to communities. Having a sense of control over their own lives, and a sense of value about where they sit within society, that they are contributing importantly (CH Hp Int. 1).

Another described Aboriginal women's health as;

Lots of strong connections between family and health and well-being, and people's overall harmony with their existence. Moving away from the health model to a well-being and connection to community. Also healing from past trauma. Looking at the broader view of health, at people's well-being instead of what is wrong with them (AH Hp Int. 2)

Many acknowledged the significant role that Aboriginal women play in Aboriginal communities and the importance of supporting them to continue doing this. One said;

Aboriginal women in the community are the people who are getting us through at the moment, and what I would hope is that we can be providing a greater level of support for the women who are doing that work. Because they are leading our communities and we need to make sure that we are supporting them to be healthy as well (AH Mg Int. 2)

And some looked forward to a time when Aboriginal women could experience health and well-being more equitably with the rest of Australian society.

I would like to be down the track where the issues are mostly resolved and it is much more about prevention; that Aboriginal people were enjoying the same benefits as others and could become the worried well, just concerned about the ordinary things rather than dealing with these

incredible crises. If we could pull out all the barriers so that they could access support when they needed it, that they have all the information, education, support and services, all culturally appropriate to be able to meet their own family needs (CH Mg Int.1)

And

It would be great if Aboriginal women had something near the standard of health and health care that white women and other women have, that there would be equity and opportunity (CH Hp Int. 2).

Some co-researchers interpreted the question more specifically in relation to health provision⁴⁸ and their vision for Aboriginal women's health was *improving outcomes, using indicators from ATSI reports and working on issues. Dealing with gaps in service provision (AH Hp Int. 1).*

And

A place with good access focused on a range of women's health. Having people dedicated to a health service with longer contracts so that people can feel more comfortable knowing they will see that person, without having different people coming in and out, in and out. (AH Hp Int. 3)

And finally

I think they would take more interest in themselves. The elderly ones focus on grandchildren, the younger ones who have teenage kids they focus on drugs and alcohol. And you can't focus on drugs and alcohol and look after yourself. They just forget to look after themselves and have their check ups (AH Hp Int. 4).

The ideal health service

I then asked co-researchers what an ideal health service that could improve Aboriginal women's health and well-being would involve. One co-researcher responded;

One that was flexible, accessible, involved choice, privacy, and there was trust and respect, that clients had the freedom to take on what they want

⁴⁸ I purposely left the question ambiguous as a trigger question.

rather than 'this is what is available so it is your only choice' (CH Mg Int. 1).

Some spoke of the importance of balancing top down decisions and ground up (community derived) suggestions in a range of service delivery models; community controlled, Aboriginal focused or mainstream. For example;

A community controlled model of health involving Aboriginal people in their own health care with Aboriginal Health Workers recognised as positive role models (AH Hp Int. 2).

And

Looking at ways that non-Aboriginal health services can be improved to actually provide decent services to Aboriginal people (AH Hp Int. 2).

Another added

Aboriginal health workers and receptionists would be able to make decisions (AH Hp Int. 3).

Many discussed the importance of non judgemental services that *really engage with communities* through positive relationships and partnership models, and support people *particularly when they are feeling vulnerable*. Most identified the need for a comprehensive primary health care approach, with varying emphasis on chronic conditions and health checks.

Access was repeatedly raised as a high priority. Some spoke of transport assistance, others of outreach programs going into women's homes. For example;

...finding ways of getting out into the community to women who need us most. Nungas are not just going to walk into (a mainstream) service, if they were going to do that, they would have done it 5 – 10 years ago.

...getting back out there, doing grass roots community work, stop hiding behind bureaucracies and get out there and see people. This would require training and up-skilling workers, Aboriginal and non-Aboriginal... Something that really addressed the social determinants of health (AH Mg Int.2)

One Aboriginal health worker spoke specifically about the importance of having permanency for staff to ensure continuity and stability and improved working relationships. She advocated for a mixture of Aboriginal and non-Aboriginal staff working together in Aboriginal health because;

If you have all Aboriginal staff it is going to get too much to handle. The Aboriginal staff members get it outside of work as well, so it is better to have a mixture.

The other thing is having non-Aboriginal people around who are dealing with stuff in their lives too, reminds us that it is not just Aboriginal people who have problems, it normalises it (AH HP Int.3).

These responses highlighted how co-researchers and stakeholders would like health services to occur. In reality however, things were sometimes quite different.

The realities of health service provision

After asking health professionals and managers about their ideal health service, I then asked them about the realities of providing health care at the newly developing Aboriginal Neighbourhood House/ Aboriginal Outreach Health Service. One manager within the Central Northern Adelaide Health Service⁴⁹ offered the following insight;

In order for health services to really work you need a unique connection between a community wanting a certain thing, staff having certain capacity, and the system supporting it. If you have all three, it works. If one fails, it doesn't.

The other things that impact are history – you cant turn back the clock, or wish things had happened differently, you have to work with what you have. I think we have to be really clear as workers about what we can and cannot do as part of the system.

This response provides an overview of what was happening at Gilles Plains at the time and some of the factors impacting on relationships between

⁴⁹ Central Northern Adelaide Health Service or CNAHS is one of the three health regions for Adelaide under the new health review.

community and the health system. **It is important to stress that this research occurred at a specific time in the development of the Aboriginal health services at Gilles Plains, and that some of these issues raised in this section have since been resolved.**

Health policies and programs

Staff members at Gilles Plains were employed under national Aboriginal health programs through Nunkuwarrin Yunti (APHCAP funding – see below) and/or state funded through the South Australian Department of Health. The Gilles Plains Aboriginal health services were linked to the (national) **Aboriginal Primary Health Care Access Program (APHCAP)**. This program of health system reform through a partnership approach guided the development and provision of services across the Northern Region of Adelaide from 2004 onwards. Nunkuwarrin Yunti is the agency responsible for the overall management and is a key partner in developing and providing services across metropolitan Adelaide. Three broad objectives are;

- Reforming and strengthening health systems to make them more responsive and better meet the needs of Aboriginal and Torres Strait Islander people,
- Increasing the availability of appropriate PHC services where they are currently inadequate,
- Continuing to recognise and build upon the strengths and resilience of Aboriginal and Torres Strait Islander people in a respectful and meaningful way (Nunkuwarrin Yunti 2008).

The key result areas for shared business between Nunkuwarrin Yunti and the Central Northern Adelaide Health Service were maternal and child health with a move toward a population health approach, and chronic disease management through increasing the uptake and use of the Enhanced Primary Care Medicare Item (Nunkuwarrin Yunti 2008). These activities were specifically guided by the national Healthy for Life Program Framework (Australian Government 2005), part of the 05/06 Federal Budget allocation of \$104 million to improve the health of Indigenous mother, babies and children and to improve the early detection and management of chronic disease.

Alongside these frameworks was the South Australian Health Reform that promoted greater opportunities for inclusion and community participation, strengthening and reorienting services towards improving quality and safety of services, prevention and primary health care, developing service integration and co operation and developing whole of government approaches to advance and improve health status (Government of South Australia 2003b). Staff members and managers discussed that the changes in the health system linked to restructuring were unsettling while they were occurring.

High turn over of management and staff

The first eighteen months of the Aboriginal health service development at Gilles Plains involved rapid changes of staff. In 2006 alone there were five different managers at the Gilles Plains Aboriginal Neighbourhood House/Aboriginal Outreach Health Service. While this sounds unbelievable, the changes occurred due to severe illness and extended sick leave, relocated to other sites, caring for family members, moving interstate and the tragic illness and then death of one of the managers. In early 2007 there was no onsite manager for five months. One of the staff members assumed the management role unofficially, leading to increased work loads for the rest of the team, and complexities associate with having a team member performing a management role but being given no official authority.

The impact of five differing management styles in one year

With each new manager came a new management style, interpretation of policies and priorities and this affected both staff and community members. The first manager had been involved in developing the original vision of an Aboriginal Neighbourhood House and supported collaborative community development programs with comprehensive primary health care. Unfortunately she became ill and had to take extended leave. Incoming managers were given a different mandate that led the service in other directions. One of the following managers described service provision as;

...a mixture of community development and clinical approach, but predominantly clinical. Increased access to GP services and chronic disease services is the push because the need is so high. It is not enough

to just provide community development, clinical health is needed too. (AH Mg Int.4)

When asked if there was a community development worker and she replied;

At present there is no one in that role, so it is about clinical people having community development skills. The APHCAP funding brings with it a certain mandate and this has been explained to that community group a couple of times but, they don't really understand it. APHCAP was based on the under-utilisation of Medicare. Specific funds are allocated to population health by the commonwealth, every thing we do, has to be about increased access to health services, which is predominantly clinical. It is very specific (AH Mg Int.4).

One of the original Aboriginal health staff members offered another viewpoint in an interview, saying;

We are not equipped to handle the primary health care aspect. Under the medical, there are lots of social things that come up, but we can't deal with them, we have to refer them out. People come in and ask and we go no you have to go over here or there, and they get angry (AH Hp Int.3).

Community anger and back lash was interpreted differently again by other Aboriginal health staff member who joined the service some time later. She said;

The community doesn't like the change. I'd say this place started wrong by calling it a Neighbourhood house. Now it is turning more clinical instead of a Neighbourhood house and the community doesn't like it. As far as they were concerned, they owned this place; they owned this building for years. So they are putting the word out, making it look bad. Now the health service is making rules.

The community abuse the place; leave dirty dishes, food all over the place. They abuse it. So the health service is really standing up for their rights. They can still do their arts and craft here but one of the rules is that they can't use the conference room anymore, because the conference room has material chairs and they are getting absolutely filthy. So they will just use the kitchen (AH Hp Int.4).

These three comments highlight the very different approaches and perceptions of staff members.

With rapid changes of management staff members felt they were always being told what to do with very little two-way conversation or negotiation, or opportunity to use their own ideas and abilities.

One staff member reflected;

Here at the Aboriginal Neighbourhood House the managers dictate where workers work, people get put in and pulled out constantly. It feels very reactionary rather than planned. It is not participatory, not a bottom up approach, we don't have a say in how we want to work. Management get a good idea and impose it, then we have to do it and then if it doesn't work they say 'look what you have done', and blame us. Staff members need to be involved in solving problems as well, everyone needs to be listened to. You can't expect people to be autonomous thinkers if what ever they are doing is controlled by someone else. When everything has already been sorted and decreed by a higher level. It is a very old way of working, it is about control (AH Hp Int.1).

These comments reflect a trend of prioritising policy and external knowledge over health professional knowledge, an issue also raised by Kirkham et al (2007). They recognised that unmodified and unquestioned Western scientific evidence based knowledge (and in this case management and policy knowledge) can limit health professionals' ability to meet individual clients needs, particularly Aboriginal people with ongoing health disparities.

Changes in all health staff positions led to further confusion, instability and frustration. Reasons for staff changes were short term contracts, being reallocated to other sites, or leaving the organisation altogether (AOHS FG5). Only two employees remained from mid 2005 until 2007. These constant changes in the first eighteen months of the newly establishing multi-agency health service were very unsettling for staff, community members and other agencies. The employment structure for staff added another level of complexity. Some were employed by either or both the Aboriginal Community Controlled Nunkuwarrin Yunti Health Service (nationally funded) and the state

government funded community health service. Employees within mixed funding programs often found *conflicting agendas, and two bosses telling us to do two different things* (AH Hp Int.2). Occasionally project funding would be stalled while *'the state and federal government worked out how to work together'* as one employees described it (AH FG3).

Developing health services within such a constantly changing health environment, with few referral pathways and minimal support was challenging. Most staff members had not worked together before and were in the beginning stages of building effective working relationships with each other. With each staff change, this relationship building began again.

Fears about workplace safety; how safe is this building and health service?

In addition to the constant changes, staff members were also concerned about their own physical health. As well as two managers becoming ill, three other employees were diagnosed with life threatening illnesses including cancers. Remaining staff members grieved and struggled to cope with the loss while wondering if there was something wrong with the work place, if there was a *physical problem such as an unknown toxicity, or if a disgruntled community member had placed a curse on the health service* (AH D3). This concern affected their mental health and ability to function efficiently. With the high turn over of managers there was no one to monitor or nurture staff morale (AH D3).

It's been like trying to run before we can crawl

As evident from the vision statements, most staff members supported and recognised a holistic view of women's health, but their capacity to provide it within Gilles Plains and the wider health system was limited, leading to feelings of frustration and unease.

One participant said *it's been like trying to run before we can crawl, struggling to meet clients' very complex needs with only limited resources* (AH M3). One of the original staff members expanded on this saying;

Once we opened the doors it was like opening the flood gates. People came in expecting services. We were (and still are) short on staff,

resources and time. We just can't meet the need. And it is not just here at Gilles Plains we have to focus on; our team has to service the whole East/West area of Adelaide – all four sites.

We don't know how to meet the need. There are incredibly sick and needful people out there. I go home and think about them some nights. I have not slept well lately.

I can give you a few examples of the people we are working with at the moment. One woman came down from another area. She is 8 months pregnant and saw a dentist in one of the major hospitals for her broken teeth. They discharged her. We went for a home visit to see someone else, met her and discovered she has had no antenatal care. We got her booked into the Women's and Children's hospital for her delivery. On discharge she goes back to a house with 20 people living there. Her partner has taken the \$3000 baby allowance. She has five other kids back where she comes from, and she has been told she needs to get back or they will be taken into care. She has no money, is struggling with an alcohol addiction and there is violence in the home. She also needs a six week postnatal check up.

On another home visit we meet a 17 year old woman with a three month old baby from interstate. She is really struggling, has attempted suicide and has already put the baby on solid foods. Families SA have her on their books but have not seen her yet. There has been no postnatal follow up. We are trying to find services for her and her baby (AH Hp Int.1).

Everyone in the Aboriginal health service was affected by these situations. A receptionist told of her concern for women in unsafe situations that they could not find timely referrals for. For example;

We had a woman come in who wanted to leave her very violent partner. It was Friday afternoon. We rang around, but we couldn't get a placement for her in a shelter. The best we could do was a motel (maybe). In the end, she said forget it, and she went back home to the violence. I spent all weekend worrying about her, wondering if I would see her on the news (AH Hp Int.4).

Even the seemingly non-complex tasks like a hearing program for Aboriginal children in schools became difficult. One staff member explained;

We (the Aboriginal health team) planned a program of checking all the Aboriginal children in the local schools over the term. At our first visit we found huge health, financial, housing, social and safety issues for one family grouping involving 40 children and adults. Most of these people were experiencing a range of physical, social and emotional issues including violence and addictions. Some of the children required immediate interventions including hospitalisation and mandatory reporting (AH D7)

The selective primary care prevention and health promotion program suddenly ground to halt as these clients filled the clinics and referrals for the next few months. Staff found that using a selective primary care approach was inadequate, and that the underlying issues spilled out regardless.

When I asked Aboriginal health workers, a nurse and doctor in a meeting what they believed the most important aspects of Aboriginal women's health were, they identified that *loss and grief, social and financial concerns, family violence, being a carer for many families and community members, past and ongoing trauma, social chaos, colonisation practices and discrimination* were affecting the health and well-being of Aboriginal women's that they were seeing (AH M4). There was no manager at the Aboriginal Health Service at the time, and staff members dealt with the difficult complexities and as best they could. Some staff members anguished over the mandatory reporting process but there was no one for them to debrief them or talk about vicarious trauma⁵⁰, just each other.

Co-researchers reflected that the holistic services and support that many clients were seeking were getting harder to provide through community health services at Gilles Plains and elsewhere. Their experience was that the community health system was aligning more closely with selective medical / clinical primary care than comprehensive primary health care, with decreased support for community development models (Baum 2008; World Health

⁵⁰ Vicarious trauma is trauma experienced by those who work with people who have been traumatised.

Organisation 1978, 1986). Clients who had experienced and enjoyed comprehensive care in the past were confused about why such services were not continuing. Deeper discussion and reflection identified that a major difference between community development and holistic primary health care models and clinical/primary care models involved *the level of client participation in their own health care, and continuation of client contact*. In community development models, staff members engage with the same community members and groups over a longer period of time, building (and sharing) skills and capacity, which can then be shared wider in community. In clinical models there is a higher turn over of clients as they receive a service and then move on. One of the tensions at Gilles Plains was that clients who were seeking ongoing contact and support (such as the women in Focus Group One) *kept on returning to the clinic for repeated visits*. This was viewed as *monopolising services and over servicing* (AH Int. 3) by some health professionals. Through our conversations, collaborative interpretations and analysis, staff members began to recognise that the community women's behaviours may have been linked to seeking ongoing contact rather than purposefully *'taking more than their share of services'* (AH Int. 3). This realisation helped to defuse some of the antagonism toward local community women, opening the way for new ways of working together.

Busy complex clinics, very ill clients & vicarious trauma

The medical clinic was very successful but incredibly busy. Drop in appointments were soon changed to an appointment system and a second doctor was employed. A system where Aboriginal health workers saw and screened all clients was established to help ensure more Adult Health Checks, Child Health Checks and chronic conditions monitoring were achieved. Many clients to the health service were acutely ill and it was not unusual for the receptionist to observe *we had to call the ambulance again this week, for someone in clinic. They were that sick we sent them straight to hospital* (AH D3). Most clinic clients had social, emotional and mental health concerns alongside acute and/or chronic illnesses. One staff member observed *we don't have any straight forward consults in this clinic; they are all really complex, needing lots of referrals and follow up* (AH D6). The clinic was meeting client

needs, but was incredibly resource intensive. The doctors rarely took a lunch break.

Another difficult factor relating to the clinic for staff members was the high incidence of illness and death occurring at younger ages in the Aboriginal community, particularly related to diabetes and heart disease. When one client in her late thirties died, the staff members were visibly upset, saying *it's not right, and she was younger than me*. They were faced with the reality of Aboriginal community health inequities every day, and often it was overwhelming. There were no debriefing mechanisms apart from talking with each other.

Between a rock and a hard place; client & health service expectations

Against this backdrop, the local Aboriginal women (from Collaboration Area One) were asking for a craft group or women's group. However, there was no worker employed at the Aboriginal Neighbourhood House/Aboriginal Outreach Health Service with a community development, women's health or social emotional well-being focus. One staff member said;

We know what they want, but we just don't have the staff to provide it. The best we can do is to provide a room and some craft items for them (AH D3).

Another said;

... even if staff were available it is not a priority for the health service; we are at the bottom of the decision making hierarchy. Even if we wanted to help them, we have little ability or support to do so (AH D6).

One staff member discussed that the local community women had come in and gotten very angry about there not being support for a group. She said *it's not my fault, and I can't deal with their anger on top of everything else (AH D2)*. Another commented *we know what the local women want is important, but when you have really sick people coming in from The Lands (remote areas) we need to prioritise their immediate health needs (AH D5)*.

The high and immediate needs of acutely ill people from other areas had a large impact on service availability for local women. One worker explained

that there was a perception that local Aboriginal women would access services elsewhere, but she challenged that view saying;

Local women are told 'you can access any urban service; you know where to go; remote area women don't. But many urban Aboriginal women are not aware of what is available, or they are too embarrassed to go there. They only go to what they know, here, the main hospitals or what they have been told about (AH D7).

Staff discussed that it was hard to prioritise a *feel good program* over an acute health crisis when there were not the resources for both.

Understanding and working with culture

Another aspect discussed in this Collaboration Area involved understanding and working with different expressions of culture. Most co-researchers identified the importance of respecting very personal expressions of culture.

Culture was described as flexible and dynamic, a deep part of who people are;

The way you express your deep down understanding and beliefs. People sometimes make judgements about people's culture and their cultural connections but it is very hard to judge how connected a person is to their culture. You can't really do that because no one can get inside a person and have an understanding how they feel deeply about things (AH Hp Int. 2).

Urban Aboriginal culture was seen to be particularly dynamic. One non-Aboriginal participant discussed;

I was talking to a teacher of a school who was saying that they had some Aboriginal young people come up and dance there. They did a Traditional dance and then they broke into a break dance. She was really put out and said that is not culture. But it is; it is part of their culture today. Australian perspectives are so weird, so categorised and boxed (AH Hp Int.1).

Understanding and interacting with differing cultures was seen to be an 'on the job' learning experience by both Aboriginal and non-Aboriginal co-researchers.

One non-Aboriginal person discussed how she learned to work well with Aboriginal people, saying;

When I first started working in Aboriginal health I was taken under the wing of the community, and over many years they taught me how to be. I guess just having an appreciation of the worth of people. You could call it cultural safety or respect or sensitivity or whatever the latest jargon term is, but I think it is about having an active interest and desire to work in the area and working in a fairly respectful way works (AH Hp Int. 2).

An Aboriginal colleague explained that there were many different expressions of Aboriginal culture and what she had learned was;

You have to kind of see it and be in it to actually know and learn that kind of thing; it is not something you can learn from a book, because every situation is different. You need to be aware that each person is different and they come from different groups. And everything you have ever been told, just wipe that from your head and go from now. From the moment you step through that door, leave your assumptions behind. Have respect, be non-judgemental, see them as individuals, and see them for who they are. Not all Aboriginal people believe the same things and have the same reactions. Don't assume they are the same. It is like every non-Indigenous person, even if you are all light skinned you might be from England, Denmark, Sweden – you are all different. Why isn't it the same for us? (AH Hp Int. 3)

These comments resonate with concepts of cultural safety that involve moving away from cultural awareness and generalisations to recognising people as cultured beings with individual lives, beliefs and priorities. Most co-researchers identified that there were many different personal and community expressions of culture, and that they did not make assumptions about what someone might need according to where they came from.

One of the managers reflected on the need for the wider health system to support non-Aboriginal people to come to understand how to be more culturally respectful;

We need our systems to support non-Aboriginal people to learn how to work in culturally respectful ways, otherwise people will just back off. People make mistakes, they feel attacked, or they feel what Nungas feel,

and they back off because of that too. We know that you just have to keep on working, even though it happens to you. I do know of non-Aboriginal people who get turned off completely (AH Mg Int. 2).

She highlighted the need to move beyond an awareness or sensitivity to cultural needs, to thinking about;

With this knowledge that I just got taught, how will that change my behaviour, what will I do differently? And if my assumption is that about Aboriginal people, what does that mean? (AH Mg Int. 2)

One of the non-Aboriginal co-researchers from the campus discussed the complexities that she has grappled with as a white employee working in the area of Aboriginal health by saying;

Aboriginal people sometimes say that white people don't know what they are doing because they are not Aboriginal, but I have seen Aboriginal people do and say some really strange things to each other. I don't think you can say someone is, or is not capable of anything based on race or colour alone. It is more complicated than that. Other things come in to play. You come to realise that there are layers and you understand politics, power and discrimination more, you see your place in the world differently. You realise there are many things that people share in common like class, homelessness, struggles, violence, neglect, regardless of race (AH Hp Int.1).

This viewpoint resonates with concepts within postcolonial feminism; that there are differences and similarities beyond culture and colonisation; gender, socioeconomics, employment status, race and personal attitudes also play a role.

Recognising the impact of discrimination, colonisation & exclusion

Discrimination, colonisation and exclusion were repeatedly raised as complicating factors affecting Aboriginal people's (clients and staff member's) health and well-being. One co-researcher explained the significant effect of colonisation and associated practices by saying;

Colonisation is like a meteorite hit, it caused total and widespread devastation for us Aboriginal people. Who do we want to blame for it? It is not as if everyone is evil. I just don't believe that every one who came here is evil. But still, that is what it has done. Devastate (AH Mg Int. 3).

One older Aboriginal health worker explained;

You get people who end up like myself, who manage the system learn how to play the game, I am doing Ok, I survive, all those sorts of things, and then you have got people who are completely disadvantaged and dispossessed (AH D6)

A younger Aboriginal staff member said;

It causes a lot of heartache because I have family who have been part of the stolen generation. They have the stories that still stay with them and we still listen. Your head is still being filled with those stories and you can't escape it, it has happened, it is always going to be passed on from generation to generation. It is who you are. It gets stuck with you (AH D7).

She went on to say;

There is so much discrimination, knowing that there are so many discriminating people out there really knocks you back. The discrimination is so real.

Other co-researchers spoke about;

...hugely, broken spirits. And that is what I call our people with all the mental health, it is not mental illness, it is broken spirit. It is broken down (AH Hp Int. 4).

Another spoke of;

The burdens of generation after generation of not being heard, valued, lifted up (AH D7).

And

In the clinic I find people have been so traumatised generally from life (AH Hp Int. 6).

One non-Aboriginal staff member shared her understanding of discrimination and how it impacted on Aboriginal people's responses;

...discrimination is in everyday life for Aboriginal people, so much so that even if someone is the last in line in a queue they think it is because they were deliberately put there. People face so much of it; it is no wonder that they see it even when it is not meant (AH D4).

Some linked colonisation to past history, particularly the Stolen Generation;

One woman said that from the age of 8 years old, she and her sister had internal examinations every time they went back into a home. She said she hates going to doctors now (AH D9).

Other related to more recent events. For example;

The wiping of ATSIC, all of the Aboriginal controlled organisations being wiped out now; it is the beginning of wiping everything Aboriginal out. One can only think that it is just going to get worse. You are not going to be recognised as an Aboriginal, only recognised as an Australian. Your whole culture, your whole identity wiped out; that is what they are trying to do (AH D7).

Health carers role in understanding colonisation effects

One Aboriginal manager explained how colonisation and disadvantage affects people's decision making and that this needs to be understood better by health carers;

I think it is teaching basic attitudinal changes. Because what people are brought up with is what they bring to their work. People will say 'well that person chose not to do that' which is fine, except that if you have a community with such a high level of need (and such a high level of disadvantage) I question what choice means. You've got to start questioning the idea of choice. Because if they are choosing something and you know that is going to put them at such a disadvantage, what does it mean? What does it really mean? Generally people don't get to choose from two evils, all the time. Generally they can choose one option that is Ok. But some communities and families don't get that choice.

It fits with the social determinants of health. It is no use hiding behind something in order to make it look different. In order to say we can't do this work because we have these individuals doing blah. It would be fine if our community was equally OK, but they aren't.

So we need workers who understand these things, and that requires an attitude shift for many. And we need a system to support them, managers who understand. And we need to try it more than once, we need to keep trying. There are few people comfortable with that kind of work, but I think that is what is needed (AH Mg Int. 3).

This explanation reinforces the importance of cultural models of practice that challenge health professionals underlying attitude and beliefs, and support them to work in culturally safe and respectful ways. In order to do this, they would need manager and health system support.

Doing what works - taking extra time and care

One participant identified the importance of taking extra time and care with clients in recognition of the huge impact colonisation, discrimination, inequities and disadvantages have on many Aboriginal people's health and well-being. She said;

We see people who are so traumatised generally. There will have been so many issues that have alienated people from services, so we try to make each interaction even more positive in every way for the person so that they end up having a positive experience. Even if we haven't actually fixed the problem, if we are working to make positive relationships, it is a start.

It is unrealistic to think that people solve problems and fix things behind closed doors in a very insular way, but if you can give people the tools to help them through a process than that is a way of looking at it (AH Hp Int.2).

However, finding effective and useful referral pathways were often difficult.

Sometimes we refer women to providers who say yes we see Indigenous people, but they are not particularly appropriate. So even the referrals

that look good on the surface, may not be. We usually don't send people to places we don't know. We sus it out first, it is terrible to send someone to somewhere where they don't get good service. Sometimes people's lives are just chaotic and that is what prevents them from meeting the appointment. We often have Aboriginal Health Workers pick them up and take them if they have had repeat non attendances. I think it is important to recognise that people have a lot of fears and anxieties about accessing some of the things we are talking about, and also other priorities that come up. Chaotic priorities like where they are going to get a meal from that day, or they just cant do it, or the kids get into trouble, or something happens, or it is just too much because they have so many other stressful things happening. Soit is not just a matter of transport, it is other levels of support.

I sometimes think it is almost like there are two completely different systems, there is the really structured health thing and then there is the scope of women's lives which might be chaos. It is almost like there is a square cube box and then there is this chaos (AH Hp Int.2).

There were also positives in referrals as she went on to explain;

Actually the appointment system and the tertiary services- usually if you ring up and explain the situation the response is pretty good. They are not punitive or nasty or anything, there is an understanding that people's lives are not always conducive to making appointments. I can't tell you how many times I have to do it, ring up and beg for another appointment, and there has never been any abuse hurled at me (AH Hp Int.2).

This highlights the extra time and care taken to provide culturally safe care for high need Aboriginal clients. Taking this extra time and effort often meant longer clinic appointments, working over hours and missing lunch breaks. The question arises – how sustainable are these working practices. Another worker who was trying to meet client needs and fill the gaps on service provision said *I think I am burning out (AH Hp Int. 1).*

Identifying and mapping services, gaps and possibilities

All participants were invited to be involved in the action phase of the research. Those who chose and were able to become actively involved were one nurse and two Aboriginal health workers, with others joining in on particular events. Other staff members, managers, and Aboriginal community women were positioned as stakeholders, who assisted occasionally. One of our first collaborative activities was a *mapping exercise* that identified what services were available at Gilles Plains, what the clients' needs were, where resources, referral points and possibly supportive people and programs were, and how they could become involved at Gilles Plains. Our mapping exercise took place over time in a variety of settings and styles; outside under the tree on big pieces of butcher's paper, if the weather was enticing, inside on the white board, or in exercise books in people's offices. Mapping in this way enabled information to be shared visually and audibly accommodating different learning, sharing and knowledge styles. Everyone present participated in the creation of the maps, writing words, drawing connecting lines, grouping together similar concepts, and clarifying points with different colours. Through this process a collective understanding of what was working successfully, what needed attention, and where the gaps and possible additional resources were, developed. In addition to client needs, and organisational priorities, key health documents and health directives were added. At a time when managers were rapidly turning over, this mapping exercise became a localised strategic plan for these health professionals.

The importance of celebrating successes

An important aspect of the mapping was identifying and celebrating successes, rather than focusing solely on the gaps and difficulties. Aboriginal women in the community consultations highlighted the need for celebrations to *help stop the burn out, for staff and for community women and a really important part of our work, celebrating culture, celebrating the successes, even small ones*. One woman simply said *if it is positive, then celebrate it* (community consultation 3 & 4). Co-researchers in this Collaboration Area identified a variety of successes ranging from the popularity and success of clinical services provided by Aboriginal health workers, doctors, and nurses, to a well attended health

expo health promotion activity involving primary and secondary Aboriginal students.

Another success was that some staff had stayed with the health service through its changes and chaos, and became the backbone of the organisation. Many staff members were also taking courses and training as part of workforce development and celebrated completion of each component with special morning teas.

Focusing on successes enabled a *strengths based* approach that reaffirmed co-researcher's skills and abilities, and what had already been achieved. For some it helped to 'give us the strength to keep going when the going gets tough' (AH D5).

Working with unpredictability and chaos without blame

In thinking about collaborative action, co-researchers identified that they would like to work together in ways that were non-blaming. They identified that health sector programs and policies *assume there is predictability in the work that we do*, when their experience was that *there is not*. They too often felt that blame was directed onto workers, managers and clients if *predicted outcomes are not achieved*, leading to a feeling that *if we only worked harder or smarter, top down goals could be met* (AH D6). Together, the co-researchers and I discussed that predictable outcomes in Primary Care were linked to Western scientific beliefs of logic and science, rather than the socio/economic/cultural realities of people's lives as in understood in comprehensive primary health care. Co-researchers stipulated that collaborative action needed to be flexible and responsive, and if proposed actions did not end up the way they were first intended, then energy would be spent on understanding what did happen and what best to do now, rather than casting blame. They identified the need for back up plans, flexibility and responsiveness. They also needed the collaborative research to complement rather than complicate their current work load.

Co-researchers were drawn to the PAR approach being developed in Collaboration Area One with community women, in particular the focus on non-hierarchical decision making, and continuing cycles of Look and Listen,

Think and Discuss and Take Action. Some of the co-researchers were able to be involved in meeting Stringer and understand his interpretation of PAR more clearly. They saw possibilities for high impact with the minimal resources and time available. As identified by Dana Shen, Aboriginal Executive Officer of Human Services, any effective actions needed three aspects; the community would want to be involved, staff would have the capacity and the system would support it (Shen 2006).

Supporting each other through the difficult times

It was important to address co-researchers' immediate issues and concerns before trying to focus on increasing client access and health care programs. Stringer (2007) describes a process beginning with the co-researchers highest priority, and then working outwards in a spiral pattern. Eventually, and more effectively, the process will touch on the issue that the action researcher is co-ordinating (in this case Aboriginal women's health and well-being). By following this process, many of the personal priorities, issues or circumstances that can prevent collaborative action from succeeding are attended to along the way.

Co-researchers were concerned about the lack of resources, support and short term contracts that were leading to such a high turn over of staff. Without improvements, it was difficult for them to maintain current services much less maintain any form of collaborative action. They felt that unrealistic expectations were placed upon them, and when they could not meet these, they were *blamed* (or blamed themselves) for their deficiencies. On one level they knew that their organisation could not meet complex client needs, and that on any given day, their services could be, and often was, thrown into chaos. Unfortunately such realism is not often written into local, organisational, state wide and nationally health policies. They felt that there was an unspoken assumption that health strategies can be successfully implemented as directed from above, if workers only tried harder or worked better.

Co-researchers spoke of feeling excluded from decision making and strategic planning processes. One said '*our requests go up; they think about it, the directive comes down. There is not much discussion*' (AH FG3). There was

often a gap between directed strategies and the realities occurring at the operational level (for example the health checks in primary schools that uncovered a family of high needs). The newly developing health service had no basis or 'normality' to bounce back to, it was still growing, shifting and forming within a health system that was also shifting and reforming.

Most of the staff members and co-researchers were Aboriginal women. As well as being health professionals, they were also members of Aboriginal communities, with close links to families and community situations. I, as a non-Aboriginal nurse could go home and forget about work but many of these women went home and continued to work unofficially. These added layers of complexity are important to acknowledge and have been explored in other studies (see for example Genat 2001). During the times of increased grief and loss from staff or community illness and tragedy, it was especially important for all staff members to attend to self care, and caring for each other. Often during the first eighteen months of the health service, there was no manager present to take notice of low staff morale, and staff members continued on as best they could. At these times I extended my nurse/researcher position by being supportive and suggesting options for counselling and further support. This was an important aspect of maintaining highly ethical, responsive and caring research (National Health and Medical Research Council 2003).

Choosing priority areas

In order for this research to be meaningful, the three main co-researchers and I were keen to focus on areas that needed attention, rather than things that were already working well. From the mapping exercise we had ascertained that clinical services, chronic conditions programs and school health expos were relatively well resourced and accessed. Overall however, the Aboriginal Outreach Health Service was still developing, getting to know and getting known by Aboriginal women, their families and communities, and other organisations. Due to complex local and wider historical issues, such as the organisational name change and many years of colonising and patriarchal health practices, co-researchers identified the need to actively and positively promote services and staff while also increasing networking and referral pathways.

Four priority areas were identified and these were:

- Working with other agencies to build networks and referral pathways (to better meet client needs)
- Promoting Aboriginal women's health and the new Aboriginal Outreach Health Service, and introduce new staff members to potential clients
- Working with the local Aboriginal women who were requesting a craft group/women's group (from Collaboration Area One)
- Working with young Aboriginal women in high schools (in response to policy, organisational, staff and community priorities regarding working with young people).

Prioritising local Aboriginal women's health and well-being needs

Planning for action – long and short term goals

Together we created long and short term plans. Longer term plans included strategic networking and negotiation with other organisations to increase client services such as podiatry, midwifery shared care, women's groups, and stress management. This was developed and pursued by staff members and management over time. Short term plans aimed to more immediately meet client and organisational needs while longer term plans were being developed, to put something into action quickly and effectively.

Look and listen

The first short term action that co-researchers and staff members were interested in developing involved a Women's Health Day. Such events had proved very popular in other sites. Some of the Aboriginal health workers had been involved in them before, so there was already expertise on how to plan, hold and evaluate such events. A Women's Health Day was relatively easy to organise and past experience showed that they were viewed very positively by community women. They increased networking, and assisted community and staff members to link with other service providers. Health days were a strategy

already supported by higher management, and there were specific national funding and health promotion programs available.

Think and discuss

Using a Ganma two-way knowledge sharing process (Gullingingpuy 2007), we brought together the knowledge of all staff members who were interested in being involved⁵¹, and identified important aspects of successful programs for Aboriginal women. These included the provision of food and transport, visiting guest speakers, fun and pampering activities, time and space for positive social interactions⁵². While many members of the community were requesting ongoing groups this was proving very difficult to bring into fruition with the resources available. Health days were a realistic and pragmatic way to begin providing a service and increased access while other issues were being sorted out. Community members were demanding action now, and this would enable staff members to respond at this time.

The first Aboriginal women's health day

The first Aboriginal women's health day was held in term one, 2006 with a focus on women's health screening and social and emotional well-being. Management support was sought early. One of the co-researchers applied for, and received, a \$200 Sexual Health Awareness Week Health Promotion Grant from the Shine SA. All staff members used their networks to promote the event. Guest speakers were invited from Shine SA⁵³, Breast Screen, SA Cervix Screening, Early Childhood Development, Nutrition and Speech pathology, Flinders Aboriginal Health Research Unit, and the Royal District Nursing Service.

At a meeting with the South Australian Health Department one of the co-researchers discovered that the Department was organising a women's birthing report launch on the same day, but had still to find a venue (the Minister had given her a date, and was searching for a venue at short notice). The co-

⁵¹ There was already discussion about holding a women's health day that occurred concurrent and intermingled with the PAR process.

⁵² Many Aboriginal women spoke about only getting together at funerals, and that they needed other positive reasons for get togethers – like health days.

⁵³ Shine SA – the leading state agency in sexual health, information, networking and education.

researcher invited her to give the presentation during the Aboriginal Women's Health Day, and an arrangement was made to share catering costs.

One of the co-researchers and I had begun meeting with the local high school (in our roles as community health nurses) and we invited the Aboriginal Education Worker and teachers to assist the young Aboriginal women to attend. The Aboriginal Education Workers ensured parental permission was sought, and an interpreter was booked so that hearing impaired students could participate. She also asked the young women what activities would most interest them, and relayed this information to the Aboriginal Outreach Health Service staff. I was working with the Aboriginal community women in Focus Are One at this time, and either brought, or encouraged them to bring, their preferences to the attention of staff members also.

Taking action

The Aboriginal Women's Health Day was held in February 2006. It was a multi agency health and social event quickly planned and collaboratively run. Health information sessions relating to general women's screening was provided by both local staff members and external agencies, and all women received a small bag with health information and a gift. Fun activities included painting two canvas murals, making jewellery, sharing conversation over food and generally socialising. Community women were able to meet staff members including the new female general practitioner. A healthy lunch and transport to and from the campus were provided. The Aboriginal Health Service was a women's only space for the day, allowing Aboriginal women to freely discuss many aspects of women's and sexual health in groups, and in one to one conversations, in culturally safe and respectful ways (Australian Health Minister's Advisory Council 2004; Ramsden 2002). Approximately thirty women attended.

The Aboriginal community women from Focus Group One were significantly involved, helping to set up and run activities through-out the day. One of the women facilitated the painting of the canvases outside under a tree; another took photos, while two others assisted with preparing lunch. The young Aboriginal women from the high school (and their friends) came with the

Aboriginal Education Worker and teacher/interpreter and joined in all the activities.

Evaluation/reflection – look and listen again.

An important part of our collaborative process was evaluating the day. Co-researchers and I designed a simple evaluation form that all attendees were asked to fill out, with assistance given for those with visual or literacy difficulties. The results taken from the Aboriginal Outreach Health Service report are presented below in table format.

Table 8.1 Women’s health day evaluation

| | |
|--|--|
| How did you find out about the day? | Through word of mouth (Nunga Grapevine) Health workers, school and school newsletters Janet |
| What did you like most? | Relaxed atmosphere, seeing and meeting other women Enjoying being together, social time together Painting, bead work, craft, hand massage Learning about and knowing about women’s health options Talking about health issues, diabetes Speakers, learning new things |
| How often would you like us to run a women’s health day? | Once a week, Once a month Once a term |
| What should we include next time | Clothes, make up, mini fashion parade personal grooming, makeovers, hair, body image Relaxation, exercise Murra Dreaming and art work More community and family focus Antenatal, pregnancy, post natal, breast feeding Cooking |
| Activities and programs that participants requested be run at the Aboriginal | Lunches and gatherings Beading Disability programs Hair and make up Cooking, arts and crafts, sports |

| | |
|---|---|
| <p>Outreach Health Service</p> | <p>Young mums and parenting groups More child and youth programs & services Homework programs Men's programs Sexual health</p> |
| <p>What are your main health concerns</p> | <p>Diabetes, Don't know, disability, weight control, dental, back and joint problems, fussy eating (in order of most mentioned to least mentioned)</p> |
| <p>Any other comments</p> | <p>A great day, well done to the organisers A relaxing day Who was the day for, workers or community? Thanks for a well structured day A great approach to giving out info to our young girls An impressive centre and warm approachable team This is fun We enjoyed our day Friendly lovely environment, lovely food Meeting new people was great Lovely day thank you</p> |

This evaluation was used in further discussions with and by management to argue for increased resources and ongoing programs.

Co-researchers wrote a longer report for their managers, and parts of it are included here to illustrate what is possible when people bring together their knowledge and experiences, and work together collaboratively.

The Women's Health Day (co-researcher evaluation)

8.30 We arrived to finish off the preparations, arrange the table and chairs and prepare areas for activities.

(The community women came and helped after they had dropped their children off at school).

10.00 Workers from other organisations began to arrive and help set up

The rest of the community arrived and suddenly it became very busy.... Very quickly.

We had worked up a rough time table of when the speakers would present, but that went out of the window and the event took on a more informal process. Workers presented to small groups and staff brought community and workers together depending upon the area of interest.

The food was prolific (but healthy) and it lasted the whole day and more (Aboriginal health management assisted with additional catering budget).

2.00 The minister arrived and everyone helped to take chairs out into the garden where Auntie Josie gave a traditional Kurna welcome. In retrospect it would have been nice to have a welcome at the beginning of the day.

3.00 The day continued beyond the launch, children arrived from school and enjoyed the food and joined in with the arts and crafts activities that were still going.

We gathered as many ideas from the community for future programmes and services, we managed to get quite a few written responses and there was definitely community interest in having another day, however we felt monthly would be a bit of an ask.

If we had to do it again... more time to plan, less food, plenty of arts and crafts, more massage, and a week off to recover.

In addition to the formal Aboriginal Outreach Health Service evaluation, I had opportunities to seek additional evaluation from co-researchers and stakeholders during research interviews and discussions following the event. The Aboriginal women from Collaboration Area One said that the day was very positive and they felt like an accepted part of the Aboriginal Outreach Health Service, *valued and included for the day* (WFG D4). For a day the Aboriginal Outreach Health Service felt like a community space and the atmosphere was *buzzing* rather than subdued and clinical. However, they saw this as a one off event where-as they were seeking ongoing programs. During weekly Nunga Lunches, other Aboriginal community women spoke about how much they had enjoyed getting together on the Women's Health Day, and how

good it was to get together for fun, celebration and health information rather than getting together only for funerals and sorry business.

The Aboriginal Education Worker said that the young women from the local high school had enjoyed coming and being part of the health day. They told her that they had learnt a lot by listening and joining in with activities. The Aboriginal Education Worker indicated that more time for preparation of school notices, parental/guardian consent and organising interpreters was needed to enable more students to be able to attend. As a result of the day, the high school asked if it were possible for the Aboriginal Outreach Health Service to run a program or activities on school grounds in the following term. This request was taken to management, who sought additional funding for a youth leadership and health promotion program to be facilitated. This is discussed further in Collaboration Area Three.

The Elder women in the Aboriginal Women's Reference Group were very pleased to hear about the day, and in particular, about the inclusion of the young women. They reflected that it was *Nunga way for young Aboriginal women to be taught about women's health and well-being in women's groups with different generations sitting together* (Aboriginal Women's Reference Group 2005).

The Aboriginal Outreach Health Service staff also enjoyed the day. They reflected that it was *a lot of work to pull it together, but working together made it possible. In many ways it was easier to provide a one off day than an ongoing program* (AH D7).

Focusing on young Aboriginal women's needs

After the Aboriginal Women's Health Day, co-researchers and I met to plan where to from here. They made a pragmatic decision that they could manage one event per term. There was high staff, organisational and policy interest in prioritising work with the young Aboriginal women and so term two activities focused on supporting a program at the nearby high school. Management obtained additional funding, and external facilitators worked with Aboriginal health staff to provide a Leadership Program at the local high school. In the

third term a young Aboriginal women's get together was held at the Aboriginal Outreach Health Service, bringing together young women and workers from the local high school and a regional community Aboriginal centre, increasing two-way knowledge exchange between young women and female workers. These two collaborative events are discussed in more detail in Collaboration Area Three. From the co-researchers' perspective, these activities assisted them to increase access and information by young Aboriginal women, something that had been difficult to do in their existing programs.

A second Aboriginal Women's Health Day

Towards the end of the year, co-researchers and community women felt it was time for another health day. The need for Aboriginal women to come together, meet and support each other and celebrate life again was high, as there had been too many deaths over winter. There were many suggestions on the evaluation forms from the first Women's Health Day that staff members wished to address. Once again we invited the young Aboriginal women from the high school to attend, which they did.

The second Aboriginal Women's Health Day was prepared and run similarly to the first. Once again transport and catering were supplied. Activities focused on stress management and well-being issues, addressing the growing numbers of requests for assistance with mental and emotional well-being. There was massage, hand care, stress management strategies and activities. In my nursing capacity I provided a very interactive and fun filled session on contraception and sexually transmitted infections. Some of the community women were very knowledgeable and we bounced ideas backwards and forwards across the room, using laughter and humour. This interactive style enabled Aboriginal women's knowledge to be intermingled with Western medical knowledge in the style of Ganma (Yunggirringa & Garngulkpuy 2007). A Tai Chi session (linked to falls prevention programs) was provided by the North East Division of General Practice. This was so well received by the Aboriginal women that the Aboriginal Outreach Health Service was able to negotiate for it to continue as a weekly activity throughout 2007.

Sexual health training

Throughout 2006 one issue that kept arising in practice and in the research data (*look and listen*) involved sexual health. Education staff came to the Aboriginal Outreach Health Service with concerns about sexual health and risky behaviours of students in the primary and high school. Community women raised concerns about teenage pregnancy, untreated sexually transmitted infections, risky behaviours and how to talk with the young people about these things. Staff members at the Aboriginal Outreach Health Service were not sure how best to work with clients about these issues. We discussed options and a wide range of people, including Aboriginal community women and staff members at the community and Aboriginal health services and both the primary and secondary schools, expressed an interest in learning more about sexual health (*think and discuss*). A range of training options, resources, professional and community support was explored, and a series of discussions about strategies toward increasing the capacity of community people and health and education professionals to support young people regarding sexual health began.

Aboriginal Outreach Health Service staff and community women expressed an interest in attending the Shine youth worker's course (*taking action*), and asked if it could be held at Gilles Plains. I co-negotiated for Shine SA to provide a six day SE&X young people and sexual health course with sponsorship enabling two Aboriginal community women (from Collaboration Area One) to attend. Originally senior high school students and the Aboriginal Education Worker were also going to attend, but date changes and a clash with exiting education commitments prevented this from being possible. Two facilitators provided the course; one an Aboriginal woman, the other a non-Aboriginal man (who later discovered he had Native American ancestry). Plans were made for single sex viewing of videos and explicit resources if necessary to maintain cultural safety for all participants.

Having been alerted to recent conflicts between some of the Aboriginal community women and staff members, the facilitators were able to maintain a safe space for all participants most of the time. However, toward the end of the course, a conflict arose between a staff member and a community woman

during a session on power and powerlessness. The skills of the facilitator decreased the impact, but the community woman felt unsafe and chose to finish the course separately. This conflict was a reminder that even though group agreements may be made, external issues may overspill into scenarios making them less than safe for those in positions of least power.

General overall participant feedback regarding the sexual health training was positive. Some Aboriginal health workers found that it assisted them to approach sexual health issues more confidently in their work place, and they appreciated being involved in a nationally accredited course. Two Aboriginal health workers who were ‘strongly encouraged’ to attend, found it less than useful⁵⁴. One of the community women found that it was immensely useful for a personal family situation, and the training became part of a chain of events that led to significant and ultimately positive life changes for herself and her children. The other community woman felt more informed and shared her new knowledge with community members in ways and spaces unavailable to health professionals.

Growth in Aboriginal Outreach Health Services over time

As discussed at the beginning of this chapter, this collaborative research occurred early in the development of Aboriginal Outreach Health Services at Gilles Plains. Co-researchers and stakeholders asked that those reading this thesis be given an opportunity to hear of changes that have taken place since. At the time of writing (mid 2008), the Aboriginal Outreach Health Service has maintained higher levels of continuity of staff with longer contracts and some permanent positions. The same manager has been on site for over a year. Networking and referral links with external organisations and services continue to develop, particularly with Adelaide’s Women’s and Children’s Hospital for improved antenatal and postnatal care, and Nunkuwarrin Yunti for clinical services. A Nunga lunch is held each Friday and the diabetes program that involves groups, camps and health promotion continues to strengthen. An ongoing support/healing group for Aboriginal women has been very successful and is supported by an Aboriginal social and emotional well-being worker. An

⁵⁴ The course is very confronting.

Aboriginal men's group was held for most of 2007, and there are now much closer links between agencies across the campus. To provide an example of the growth, services provided in term one 2006 and term one 2008 are shown in a table below.

Table 8.2 Aboriginal Neighbourhood House - Term 1 2006

| | ANH Services & Programs |
|------------|--|
| Mondays | Diabetes group |
| Tuesdays | Afternoon clinic 1 doctor & Aboriginal Health Worker |
| Wednesdays | |
| Thursdays | |
| Fridays | Clinic 1 doctor & Aboriginal Health Worker |

Table 8.3 Aboriginal Outreach Health Service - Term 1 2008

| | AOHS services & Programs |
|------------|--|
| Mondays | Podiatrist (Nunkuwarrin Yunti) Diabetes Group |
| Tuesdays | Women's support group (counsellors & AHWs) Afternoon clinic 1 doctor & Aboriginal Health Worker (joint Nunkuwarrin Yunti and Aboriginal health team) |
| Wednesdays | Men's group (making artefacts and support) |
| Thursdays | Tai chi in mornings (NE Division of General Practitioners) Stress management afternoon |
| Fridays | Clinic all day Computing training with Technical and Further Education (TAFE) lecturers Nunga Lunch (a free, nutritious, community lunch) |

(AHS FG March 2008)

These tables show how services at Gilles Plains Aboriginal Outreach Health Service increased and became more focused on comprehensive primary health care and that more programs, staff members and collaborations became available over time.

The significance of our collaborative research

Co-researcher reflections

In early 2007, I invited the main three health professional co-researchers at Gilles Plains Aboriginal Outreach Health Service to reflect on what the PAR/collaborative work had meant from their perspectives, and what impact it had had for the developing health service. At our first meeting, co-researchers were trying to meet a submission deadline for additional funding. There was no on-site manager at the time, and so staff members were writing the submission themselves. In recognition of their priorities and challenges, I assisted them with their submission and returned again later.

On the second visit I was able to meet the two Aboriginal health workers and nurse in a quieter moment and record their thoughts on butcher's paper. In relation to the research process activities and outcomes they said;

There was great value in talking things through. As women, we often have the ability to work through the ideas swirling in our heads while we talk with someone who can listen to us.

We really appreciated the debriefing, particularly when there was no one else to talk to.... During the really difficult, confusing times, it has been good to know that someone was listening. Sometimes it felt like others don't really appreciate our work and our battles (others could include community members, peers, other agencies, management, policy makers etc).

The mapping exercises have been useful to see where we have come, and where we might be heading.

The PAR process has given us an opportunity to pull things together in a concrete but flexible way, when there is no structure and it is all swirling around us.

It has helped as we try to pull services and pathways and systems into place with minimal resources.

When there are so many distractions; it is hard to concentrate on what our jobs might be, the collaborative process gave us options and different ways to meet a range of needs

Having you around has helped us keep the Aboriginal women's health activities (non clinical) on the agenda.

Having someone like you being able to work with the community women (from Collaboration Area One) was good. You could do what we could not, at the time.

Looking back, this research was an important part of the health service development (AOHS review 2).

These responses indicate that being involved in this participatory action research has been a positive experience for co-researchers. Our collaborative approach ensured that the research process and outcomes could complement and support health practice, rather than complicating it. According to these co-researchers, at times the research has offered much needed direction in the face of confusing and overwhelming demands. Its capacity building and people oriented focus has ensured that support has been felt at both professional and personal levels. Looking back, co-researchers also reflected that the collaborative research had helped to improve relationships between Aboriginal community women and the Aboriginal Outreach Health Service, in particular the women from Collaboration Area One. The Aboriginal Women's Health Days were discussed as being significant positive strategies in the growth of the health service.

Stakeholder reflections

Aboriginal community women from Collaboration Area One viewed the activities in this Collaboration Area with mixed feelings. While they generally enjoyed events such as the Aboriginal Women's Health Days, they were frustrated with the ongoing delays in the provision of the kind of women's health services they had previously received, needed, and continued to seek. The women said *yes it was good, for a day. Then the next day it went back to how it was before* (AWG R2). Over time however, they became more involved with ongoing groups and programs. Looking back, the women discussed the

importance of my positioning as a communication link between the Aboriginal Outreach Health Service and themselves, someone who could explain what was going on, and why.

Community Health staff members were particularly supportive of the collaborative activities in this research. One said *'it was a relief to know that someone was in there supporting staff through the hard times and that something was happening for the local women who had waited for so long* (CH D3). Although there was Community Health Service agreement to *wait until the timing was right* for collaboration between health services, individual community health staff members recognised that Aboriginal Outreach Health Service staff members were struggling, and Aboriginal community women were continuing to wait for particular health services.

My reflections as a nurse researcher

Being positioned as a nurse researcher enabled me to *be with* Aboriginal health professional researchers, while also *being with* Aboriginal women co-researchers from Collaboration Area One. Postcolonial feminist concepts of multiple perspectives enabled me to recognise that Aboriginal and non-Aboriginal health professionals, managers and community women were situated in complex and ambiguous positions, experiencing differing levels of capacity, resistance and agency at different times and in different situations (Browne et al 2005; McConaghy 2000). I was able to navigate the complex relationships and changing dynamics that existed within, and around this and the first Collaboration Area. Having said this, maintaining a role of 'connected neutrality' and negotiation was personally difficult, particularly during times of heightened conflict. Safe and confidential debriefing strategies helped me to deal with the frustration and confusion of becoming a negotiator between health professionals, management personnel and community members.

Themes and discussion

In this section I discuss the findings from this Collaboration Area under the themes of knowledge sharing, working together and addressing issues.

Knowledge sharing

Just as the Aboriginal women in Collaboration Area One valued being heard and having their knowledge recognised, so too did the co researchers in Collaboration Area Two. Aboriginal and non Aboriginal health professionals (specifically Aboriginal health workers, nurses and receptionists) working at the Aboriginal Neighbourhood House/Aboriginal Outreach Health Service, spoke of feeling unheard, unrecognised, and unsupported by management and the wider health system. They indicated that top down health policies and management structures were implemented regardless of what they believed was important. This left health professionals feeling that they did not have professional autonomy or any real impact on how the health service functioned.

As well as being incredibly frustrating, this situation directly impacted on client care. As discussed by Kirkham et al (2007) unmodified and unquestioned externally derived evidence based practice severely limits a practitioner's ability to meet individual client needs, particularly the needs of Aboriginal people with ongoing health disparities. Top down policies and practices that promote a *set recipe* approach do not take into account deep rooted social, economic and historical factors (Baum 2008; World Health Organisation 1978). This scenario played out repeatedly at Gilles Plains. For example, the selective primary care hearing program in schools was based around a simple and succinct plan. Health professionals would go into local primary schools and test children's hearing. A timetable was drawn and plans put in place. However, at the first school visit, staff members came across significant health, financial, housing, social and safety issues in one family grouping. On further investigation, over forty children and adults in this one family grouping were identified as needing immediate health care. The complexity and depth of the physical, social and emotional issues including violence and addictions meant that the health clinic was full for the next two months. Other strategies required included hospitalisation and mandatory reporting (AH D7). Co-researchers discussed feeling overwhelmed during this process, but had no one to talk to about it, besides each other. There was no

manager on site, and no one else allocated to support staff members through the difficult times.

Co-researchers discussed that not only did they have to deal with unexpected outcomes with limited resources, but they felt that they were blamed by managers, policy makers, clients and the health system when programs did not proceed according to plan. They identified that this was because the plans were simple and the situations were complex. This highlights the differences between selective primary care and comprehensive primary health care approaches. Selective primary care focuses on technical interests, biomedical and physical strategies and predictable outcomes. A program may involve conducting hearing tests, finding an ear infection, treating the ear with antibiotics, and considering the health problem fixed. In comparison, comprehensive primary health care takes a practical and emancipatory approach to knowledge interests (Habermas 1972). It involves a wider view of health that includes the wider context of physical, mental, emotional and cultural well being. If a hearing program were planned, additional supports and referral pathways would also be considered because if a child was found to have an infected ear, underlying causes to do with housing, financial, sanitation, dietary, social or safety issues would be considered. The provision of antibiotics would be one strategy amongst a wider response.

At the time of this research, the health system was using the terms primary care and primary health care interchangeably, as if they meant the same thing. One of the implications for health professionals was that there was an expectation that they would conduct and completion programs and projects, as if the work were predictable and uncomplicated. This would mean that individual client needs, issues and complexities were overlooked.

Working together

PAR as an effective model of collaborative health care practice

When it came to working together, co-researchers asked that we choose an approach that would recognise their and their clients' issues and priorities, and lead to possible solutions without adding to their existing workloads. They also stipulated the need to recognise unpredictability and chaos in health programs,

and not to assign blame. Together we discussed the possibilities within PAR and all agreed that it met the criteria. After spending considerable time discussing the issues through interviews and focus groups, we began our collaboration by mapping what was already resourced (the clinics and primary care programs), where there were gaps (comprehensive and women centred programs). Using butcher's paper, white boards and note pads, we then considered possible referrals, services and resources. Being pragmatic, we chose four priority areas that were achievable, met organisational and professional goals and could be supported by management. These were; working with other agencies to improve networks and referral pathways, promoting the health service and introducing new staff members, working with local Aboriginal women, and young Aboriginal women. We set long and short term goals that could enable us to meet immediate client needs (the women's health days), while also advocating for more sustainable change (involvement of other agencies to support ongoing women's and well being groups).

Inclusions and exclusions, collaboration and Othering

As a nurse researcher I was in the privileged position of being able to watch, hear and interact with a diverse range of community and health professional co-researchers during the development of the Aboriginal Neighbourhood House and Aboriginal Outreach Health Service. I observed that specific circumstances, policies, practices and actions contributed to the community women in Collaboration Area One being involved in collaboration and health care programs, or positioned as *the Other*, leading to decreased health care access. Discussing these highlights some aspects that influence whether Aboriginal clients become involved in health service programs or not.

The Aboriginal women co-researchers from Collaboration One experienced a period of collaboration and inclusion from 2000 – 2002 that they valued strongly. In 2002/3 they attended the Aboriginal Mothers' Group provided at the Gilles Plains Community Health Service. This was a comprehensive, women's focused primary health care program. Two of the women were also involved in a grass roots project envisioning the development of a local Aboriginal Neighbourhood House. This collaborative process brought together

community members, health managers and staff members in respectful knowledge sharing.

In 2002 the Aboriginal Mothers Group ended due to health service policy and funding changes and as a result, partnerships between the community women and health professionals decreased. In 2003/4 the four women became involved in the Family Well Being Course with an external facilitator, where they again experienced being included and working collaboratively. They were encouraged to complete train the trainer component and help co-facilitate future courses, a move that raised expectations of future collaboration. However, the course finished, the facilitator moved on, and the Aboriginal Neighbourhood House was still not open. The women fell into a gap in service provision. Becoming frustrated, two of the women became involved in community activism and writing a letter of complaint, a move that led them to being firmly placed in the position of being disruptive and '*the Other*' by Aboriginal health services and managers. In research interviews I was warned by three Aboriginal managers about *working with those women*, who had a history of *being disruptive and not following the proper channels of direct negotiation* (Mg 11, 2, 3). This negative attitude toward the women filtered down to health professionals in the newly developing health service, and was further inflamed by the angry responses of the community women themselves.

During interviews and discussions with health professionals at the Aboriginal Outreach Health Service, the four Aboriginal women from Collaboration Area One were repeatedly referred to as '*those women*'. Using PAR strategies, I sought to unpack this situation by asking what exactly *those women* did that was so problematic, and whether it happened all of the time, or only in specific circumstances. Some health professionals identified that *those women monopolised services*, and were *non-compliant and aggressive*. Further discussion and analysis enabled a deeper exploration of the situation. I had identified from the themes emerging from Collaboration Area One that the Aboriginal community women were seeking ongoing support and connection with health professionals. The women attended the clinics regularly because they were the only programs available. In the comprehensive primary health care programs they had previously attended, regular contact was expected and

encouraged. In this new clinical settings however, such behaviour was considered to be *over servicing*. The only other service available at the time was a diabetes program. Some of the women began attending. However, because they were seeking ongoing support and connection more than the health content, they were at times *non-compliant* with the program goals and expected outcomes. These community women did not fit neatly within the planned service provision and so became positioned as *the Other*, as difficult clients. They repeatedly sought services even though they were not particularly ill or suffering a chronic condition. The local Aboriginal women sought ongoing contact for their health and well being, and the Aboriginal health services sought to meet the complex health needs of a wider Aboriginal population.

Even when women focused programs were developed, the women were still positioned as the Other due to specific program foci. For example, the Aboriginal Primary Health Care Access Program (APHCAP) promoted a *partnership approach* with specific policies focusing on maternal and child health. Unfortunately this excluded the Aboriginal women in Collaboration One as they had older children. Following program target group criteria, health professionals promoted a group for young Aboriginal women at the Gilles Plains campus. The four local Aboriginal women were informed by Aboriginal Health Workers that they were not to attend because they did not fit the criteria (as per the policy). However, what occurred was that very few young women attended, possibly because the health service was still becoming known and there were few networks. There was a worker, resources and a holistic women's program, but very few clients. The local Aboriginal women observed this under-utilisation, identified their own longstanding needs and invited themselves in. The Aboriginal Mothers Group of 1999 had included and valued the role of older women as carers of children, but in this selective primary care program, the women were considered to be inappropriate participants and once again *monopolising services*.

The extent and frequency to which inclusion or exclusion, connection or Othering occurred was dependent upon many factors including personalities, people's energy levels, policies and what else was happening at the time. For

example, one health professional who was normally supportive of the women and included them where ever possible said *usually I sit and talk with the women, but one or two have been very verbally abusive lately, there is no manager here at present to deal with all the issues, I am overworked, and I just don't have the time and energy to deal with it all.* This very human response highlights that sometimes inclusion and exclusion can be complex and linked to many different factors and changes day by day.

Collaborative events such as the Aboriginal Women's Health Day provided opportunities for inclusion rather than exclusion, regardless of all of the issues that existed. Health professionals and community women were supported to work together collaboratively toward a goal in common. However, it was difficult to maintain such collaboration in everyday selective primary care programs.

In highlighting these aspects of inclusion and exclusion I am not suggesting that the Aboriginal health services provided substandard services compared to other health services. Rather I wish to highlight the aspects of any form of health care, in any health service that impacts on access and experiences for Aboriginal women. There is sometimes a misconception held by mainstream services that Aboriginal health services and Aboriginal health professionals can automatically provide the health services that Aboriginal clients need and prefer, but this is not possible. Busy work loads, interpersonal conflicts, family and community relationships, lack of resources, specific program criteria and opening times all impact on health service access. The depth and complexity of health and well being issues are often too much for one health service to deal with alone, particularly when they are linked to lower social determinants of health. In addition, sometimes Aboriginal clients do not wish to see Aboriginal health professionals because they are too close, or because the issue that the client wishes to share is so devastating that they do not want to burden another Aboriginal person with it. All of these reasons combined highlight the importance of mainstream health and associated services becoming involved in shared responsibility, partnership approaches, working together and mutual obligation as advocated by the National Aboriginal Torres Strait Islander Health Council(2004).

Addressing issues

The complexities and difficulties of health care provision

This Collaboration Area also highlighted the difficulty health professionals faced in trying to meet complex and different client needs with limited resources. Health professionals discussed struggling to prioritise comprehensive primary health care when so many clients were already acutely ill and requiring immediate intervention. They had difficulty prioritising a well-being program when clinic clients were requiring immediate hospitalisation. This mirrors wider dilemmas in the health sector regarding which services are adequately resourced, and which are not. Even though the state Generational Health Review (2003b) promotes a commitment to Health for All and the comprehensive primary health care, projects such as the Aboriginal Neighbourhood House are changed to become an Aboriginal Outreach Health Service under Medicare funding.

There are conflicting interpretations of policies and funding streams such as the APHCAP policy and funding. Some managers interpreted the policy as promoting comprehensive as well as primary health care, while others interpreted a focus on clinical services with *health professionals bringing a comprehensive view of health to clinical care* (Mg I3). These quite different and changing interpretations made it difficult for health professionals and clients determine what kind of health care was being provided, and to what extent it could address wider health issues linked to the impact of colonisation.

Recognition of the impact of colonisation, discrimination and exclusion

All of the health professionals and staff members involved in this Collaboration Area expressed a deep understanding of the impact of colonisation, discrimination and exclusion on Aboriginal women's health and well-being, and the need to positively address these in health care provision. Aboriginal co-researchers spoke from their own experiences as Aboriginal women experiencing and observing such impact every day. Non-Aboriginal staff members at the Aboriginal Outreach Health Service were also deeply aware, having worked alongside peers and clients for many years. Colonisation, discrimination and exclusion were discussed as *a fact*, rather than

a possibility to be debated. All staff members supported the viewpoint expressed in the South Australian Generational Health Review (Government of South Australia 2003a), the South Australian Women's Health Policy (Government of South Australia 2005) the 'Close the Gap' Campaign (Oxfam Australia 2008) and Cultural Respect (Australian Health Minister's Advisory Council 2004) that colonisation, discrimination and exclusion continue to impact on the lives of Aboriginal people today. They sought to find ways to address these, but often found it difficult with existing health care approaches.

The benefits of collaborative action-orientated research

Enacting the process of PAR in this Collaboration Area highlighted the importance of moving beyond interpretation into action (Habermas 1984) and (Freire 1972). Co-researchers discussed that planning and taking positive and collaborative action helped them to gain a sense of control and better meet unmet client needs. Interpretive approaches increase knowledge and understanding, but do not provide opportunities for pragmatic and responsive action and evaluation. Co-researchers valued being supported to *try something new*, without the fear of being blamed if it did not go to plan. If the action did not work out, they simply evaluated it, reflected, discussed options and tried again. Rather than being *the receivers of directed programs or scapegoats if things did not work out* (AH D6), workers became involved in 'ground up' programs where their knowledge and expertise was recognised and supported. In this way this research process became liberating and transforming in ways similar to Freire's (1972) Dialogical Education and Belenky and colleagues (1973) Connected and Midwife Teaching.

The PAR process also enabled health professionals to be able to focus on local Aboriginal women's priorities and find creative ways of addressing their needs with available and newly developed resources. Health care was able to focus on local evidence and cultural and personal needs, as well as external, top down, pre-selected biomedical evidence. In this way PAR increased health professionals' capacity and opportunity to provide culturally safe, responsive women's health programs, mindful of the ongoing impacts of colonisation, discrimination and exclusion on Aboriginal women's health and well being.

Summing up

The collaboration process

This chapter has focused on the challenges faced by health professionals within an emerging Aboriginal health organisation. Staff members were feeling caught between community expectations of comprehensive primary health care and existing primary care policy and funding. PAR became a dynamic and supportive process that identified ways of moving forward together, supporting local women's priorities *regardless and regardless* of the health system around us. It promoted a collaborative approach underpinned by greater understanding and respect of each other and the complex health system that we work with. We co-developed collaborative processes to complement rather than complicate existing work loads and organisational directives.

The next chapter focuses on collaboration between the Aboriginal Outreach Health Service and a local high school. This Collaboration Area highlights issues for young Aboriginal women, as well as ways that health and education sectors can work collaboratively together toward improving Aboriginal women's health and well being.

Chapter 9 Collaboration Area Three - The High School and the Health Service

Overview

This chapter focus on collaboration between health and education sectors that sought to improve the health and well-being needs of young Aboriginal women. Although originally I had intended to work directly with young Aboriginal women at Gilles Plains, this did not eventuate for a range of complex reasons. Rather, this Collaboration Area became focused on how Gilles Plains Aboriginal Outreach Health Service and the local high school Windsor Gardens Vocational College, could work together to improve young Aboriginal women's access to health information, services and improved well-being.

Methods

The methods used in this Collaboration Area included semi structured interviews, meetings and collaborative action within large and smaller cycles of Look and Listen, Think and Discuss and Take Action. Five education staff members participated in semi structured interviews at the school. Each participant was asked about their experiences, knowledge and perspectives about young Aboriginal women's health and well-being within and in relation to the school setting.

Thematic analysis was used during initial interviews and follow up member checking to draw out themes. In addition all data including evaluations and de-identified student feedback as discussed by education and health staff was entered onto NVivo soft ware for additional analysis. The data are presented as a series of themes, and the collaborative action generated from these themes discussed as five events, one occurring for each school term during the time of the research.

Co-researcher selection

Co-researchers comprised staff members at Windsor Gardens Vocational College who were specifically involved in working with young Aboriginal

women. These included one Aboriginal education worker, three teachers, and one youth worker. One of the teachers was also a counsellor, and another was an interpreter for students who were hearing impaired. Two Aboriginal health staff from Gilles Plains became involved for some of the time until other work commitments prevented their involvement.

Although originally I envisioned working directly with young Aboriginal women in this research, this was not possible when the research became school based due to ethical, confidentiality, and consent and time considerations. Rather, most young Aboriginal women became stakeholders of this research, and participants of specific health and education programs. One young Aboriginal woman who had already left school became involved in an interview.

Stakeholder selection

Stakeholders included young Aboriginal women students, other education staff and management, and health staff and management at Gilles Plains. Aboriginal community members and Elder women specifically were another stakeholder group who influenced this Collaboration Area; they specifically identified the need for young women to be involved in this research.

Coding of data

To increase confidentiality interviews are coded as HS I 1 – 5; high school interview 1 to 5. The interview involving the young Aboriginal woman is coded (YAW I1).

Difficulties in researching directly with young Aboriginal women

Originally when co-planning this research, I envisioned working with young Aboriginal women in Gilles Plains programs such as the campus youth group and a proposed young Aboriginal women's group at the Aboriginal Outreach Health Services. However, the youth group discontinued soon after the research began, and the young women's group did not come into fruition. Neither the Aboriginal Outreach Health Services nor I had sufficient resources

to begin a young women's group similar to the Women's Friendship Group in Collaboration Area One. A peer education program was also considered but without the ability to make it sustainable it seemed unethical unless we could work in with an existing program or organisation that would provide ongoing support (National Health and Medical Research Council 2003)⁵⁵.

In the Gilles Plains area, the majority of young Aboriginal women who were associated with a supportive structure were those at the local high school. There were no local youth programs outside of school settings. This posed an ethical dilemma for me. As a community health nurse I could go in and work with young women in schools, but as a researcher I could not. I was advised that I would be unlikely to gain ethical permission to work with young underage women in schools in the timeframes available to me, but I could apply to the South Australian Education Department Ethics Committee to interview teachers, youth workers and Aboriginal Education Workers at the local high school, which I did.

I did attempt some interviews with young Aboriginal women but discovered barriers that prevented personally and culturally safe one to one interviews occurring between them and myself. Firstly there was no relationship of trust built between us over time as there had been with the adult women in Collaboration Area One. Some of the older Aboriginal mothers did offer to ask their daughters, and some arrangements were made, but the timing did not work out due to the young women's school commitments, travel to see family and personal priorities. There were also issues related to whether the young women were able to 'freely consent' versus 'being expected' to be involved in the research by their mothers. The concept of an interview for research was also quite foreign for the young women, and viewed similarly to a job interview which I did not realise until later in the research. This too may have accounted for the inability to engage with them and arrange interview times.

Due to these complexities the voices of young women in this Collaboration Area comes from one interview with a young Aboriginal woman who was no longer in school, as well as formal evaluations from health service activities

⁵⁵ The Aboriginal Women's Reference Group members were very clear that they did not support short term projects that raised young people's expectations and then suddenly finished.

and programs, and de-identified stories and opinions relayed by education and health staff. While this is not ideal, it is how this Collaboration Area developed.

Adapted research plan - collaboration between the Aboriginal Outreach Health Service and local high school

Rather than focusing directly on young Aboriginal women's health and well-being as a subject, this Collaboration Area explores the process of health and education staff/co-researchers sharing knowledge with each other, with secondary input of young Aboriginal women, toward making health and well-being programs more accessible and appropriate for young Aboriginal women. Therefore, this research complements, but by no means replaces, research which directly involves young women as key participants such as the study by Sarah Larkins who worked directly with teenage Indigenous women in Townsville regarding relationships and pregnancy (Larkins 2007). Therefore this Collaboration Area followed the pattern of what often happens when health and education services come together to provide joint health care and education programs. Health and education professionals meet and plan programs for the students, with varying levels of student involvement.

I begin by discussing the data themes arising from the interviews and discussions with five education staff members and one young Aboriginal woman no longer in school. Most co-researchers began by discussing specific needs of young Aboriginal people, compared to other young people.

Look and listen – community consultations and emerging themes from other Collaboration Areas

During the community consultations, interviews and focus groups, many co-researchers spoke of the importance of health information and access to primary health care services for young Aboriginal women.

Community concerns

Teenage pregnancy, sexual health, violence and access to health care

Older women in the Aboriginal Women's Reference Group spoke of their concerns for young Aboriginal women, particularly regarding high rates of

teenage pregnancies or as they described it *babies having babies*. They spoke of some younger women (14 years and over) that they knew were having babies. They said;

Their bodies are not developed properly and it is no good for their health. They drop out of school and get stuck in the poverty cycle at a young age, and then they get dependent on that welfare. They think the \$4000 baby bonus from the government will see them through, but they don't understand the role and responsibility of bringing that baby up.

Some of them get into drugs, 22 of us grandmothers are raising our grand children because of drugs, that is why we have formed the Grannies Group, to support each other, and now we are talking to the minister too. We talk to anyone who will listen.

Some of the women discussed concerns about whether there were still specific programs for young Aboriginal women around sexual health and keeping safe. They said;

We used to go out and talk to the girls about sexual health and keeping themselves safe when we were Aboriginal health workers. We used to do the contact tracing, go into pubs and tell them to get checked and get medications. Who is doing that work now?

And who talks to them about good relationships and violence and that they don't need to settle for bad relationships?

(Aboriginal Women's Reference Group 2005)

The impact of colonisation on cultural women's health information sharing

Aboriginal community women identified the need for health information and services for young Aboriginal women in their care. In general discussions in the Women's Friendship Group in Collaboration Area One (WFG D5) and in clinics, some Aboriginal women said that as mothers and grandmothers who were members of the stolen generation they felt unsure about how best to bring up conversations about women's health topics such as puberty, sexuality and safety (Janet Kelly journal). They themselves had missed being told about these issues and found it difficult to know how to initiate discussions.

Traditionally, Elders and aunties would speak to young women about women's and sexual well-being, but colonisation processes had interrupted this practice. In current situations, young Aboriginal women often missed sex education sessions at school, either due to shame⁵⁶, non-attendance, or having already left school.

The need for health promotion, information and early intervention

Health professionals at the Gilles Plains Aboriginal Outreach Health Service identified that *working with young women to improve child and maternal health, antenatal care and infant well-being* was a high priority (AHS FG2). Most of the young women who attended the clinic came with an acute health problem or were already pregnant. A short term young women's group program was planned for Gilles Plains Aboriginal Outreach Health Service but very few young Aboriginal women had attended, possibly due to the newness of the health service and community members not knowing about it.

From their conversations with young Aboriginal women clients, and also from their own family relationships, health staff identified health priorities for young women as;

smoking, knowing about sexual health and sexual rights, growth and development, mental health, dealing with grief and loss, malnutrition, substance problems, well-being issues, self confidence and coping with life (AH Interviews 1 – 8).

Dealing with high levels of grief and loss at an early age

We discussed whether they felt issues were the same or different for young Aboriginal women compared to young non-Aboriginal women. The general consensus was that the issues were similar, but that Aboriginal women experienced another layer of complexity linked to complex factors of discrimination, exclusion, inter-generational disadvantage and dealing with high levels of sorry business. One worker explained;

⁵⁶ Shame is a complex emotion that has more to do with embarrassment and discomfort than being ashamed.

Aboriginal kids know more about death and dying and funerals than other (non-Aboriginal) young kids do. And it is not just old people dying; sometimes it is their friends in accidents or suicides, or family members who die young from illnesses. It happens too often for our young ones, much too often (AH I7).

Health professionals felt that such high levels of grief and loss must have a very significant affect on developing young people. *Sometimes there are funerals three times a week and that is too much for anyone, much less a young person (AH I7).*

Aboriginal women's health coordinators also raised concerns about young Aboriginal women's personal, cultural and emotional well-being as they grew up in discriminating post-colonial Australia. One women's health co-ordinator said;

Young Aboriginal women are growing up emersed in unresolved intergenerational trauma within a discriminating Australia. Where are the social, emotional, cultural and service support that young Aboriginal women need to move forwards in health and well-being (AHC I2)?

Another said;

If young Aboriginal women could experience one day where they felt safe, respected, loved and accepted, that would be a great thing (AHC I1).

This highlights the levels of discrimination and exclusion that young Aboriginal women face every day.

Co-researchers interpretations of young Aboriginal women's health & needs

Young Aboriginal women just need a little more support

All five education professionals noted that Aboriginal students usually needed additional support compared to other students in order to move forwards into work experience or the workforce, or to access new programs and services

including health services⁵⁷. This was done *without taking away their need to work through things themselves* (HS I5). Often the Aboriginal education worker or Aboriginal education teacher would sit with them and talk through strategies and ideas. One non-Aboriginal teacher expressed confusion about *why as mature, capable young women they didn't just go out there and do it*. She wondered if;

connection and talking about it with an older woman first was a cultural thing or if it was generational, linked to generation after generation of not being heard, valued or lifted up (HS I5).

She said that she had recently seen a program on television about the lost wages and ongoing fights for compensation, and wondered whether this and similar issues might be impacting on young women as they prepared to enter the work force. Although she did not name these specifically as colonisation or discrimination practices, she recognised that inequities were involved.

Another participant specifically named discrimination as a major contributing factor impacting on young Aboriginal women. She said;

They are growing up in a society that is basically discriminating. Whether any of us like it or not, it is there. The young Aboriginal women don't get many opportunities to talk about it; in fact it becomes so much the norm that they don't even know when they are dealing with it a lot of the time. So there develops this underlying belief that they are not quite good enough, or they are not OK. It becomes a thread running through what their experience is (HS I2).

This teacher indicated that repeated exposure to discrimination and derogatory comments by others undermined the young women's self esteem, negatively affecting their ability to spontaneously study and enter the work force as some other students did. She identified a unique role of the Aboriginal education worker and other supportive staff members to help the young women embrace opportunities available to them.

⁵⁷ Windsor Gardens Vocational College has a focus on preparing students for further study and the workplace.

Another participant felt that young Aboriginal women *struggled with lack of information, wrong information, low self confidence and being scared to connect with people to ask questions and get help* (HS I4). She stressed the importance in *supporting young women and helping them to get past their fears through building relationships of trust, and a safe atmosphere* (HS I4). She favoured experiential learning with the support of a trusted staff member. She indicated that the cultural background of the staff member was not important, what was important was that mutual trust and respect could be built up over time.

The impact of culture, families and social class

Co-researchers discussed mixed feelings about the impact of culture, families and communities on young Aboriginal women and their ability to succeed in school. One participant said;

I don't know what it is, this culture. Maybe it's a sense of belonging and being part of a community, having a connection and understanding the same words and gestures.

Many of the young girls have both white and Aboriginal heritage and I think we need to find some way where they claim both. (HS I3)

Another teacher questioned the 'all positive' role of culture and whether sometimes the less 'culture' a student has, the easier it is for them in the wider education and social system. She gave an example of one young woman who had little contact with her family and was raised away from Aboriginal community members. From this interviewee's perspective;

This young woman works with all the systems and social requirements well, she has no younger siblings to care for and has not been subjected to the negativeness and discriminating stuff about white people. She does not know about her heritage; she has no trouble working the system (HS I4)

This teacher placed the importance of education over the importance of connection to culture and heritage. She went on to discuss challenges for

young Aboriginal women she saw as being deeply connected to culture. She said;

Often the oldest girl can't go to school, has to stay home to look after the young ones. This then affects her school attendance. It becomes a difference between the cultural requirement and the education system. If they tell the wrong person, they know the mandatory reporting person will come in, so they don't tell. They know enough of the system to know what to and what not to do (HS I4).

Her personal perception raises questions about how differing definitions of culture, can infer that issues are cultural, when perhaps they are more to do with family situations, Western education and employment systems, and socioeconomic factors that force Young Aboriginal women and their families to make these difficult decisions. If there were alterNative childcare, work, or school arrangements the young Aboriginal women would be able to continue with their schooling while their parents continued to work, and younger siblings were in safe and (culturally) acceptable care.

Another teacher noted that class and family connections often impacted on students' abilities at school;

For some students there are limitations, it depend on the environment they are in, and the family as to what can happen next. If the girls are growing up where either one of their parents has had a lot of experience in the white fella world, then they have got a handle in a way that the others don't. So they are managing being in and learning the language of school, and the expectations, what to do, what is being a good student about. Then they go home and they may or may not have support to do homework, or be helped to believe that they can do things.

It is also about attitude, expectations, the way you treat people, how to survive in a middle class environment pretending that things are alright even if they are not. I think class has a large influence, class and employment or unemployment. Many kids in this school come from working class or unemployment backgrounds, but then the Aboriginal kids have the added layer of discrimination.

And for some there are issues of violence in the home, some have seen a lot of it and studies are showing that that this impacts on their ability to learn. It is not just Aboriginal young people dealing with violence, it happens across all cultures and classes. However I think that the high levels of discrimination that families face might be the added dimension that makes the violence flare up more often in their homes.

On the other hand, for many kids, a supportive family and community is a huge plus that helps them have a sense of belonging that is so crucial. The positive side I see of being Aboriginal is that even if you are having a hard time just now, you are part of this mob and that makes a difference for them.

That is why the role of the Aboriginal Education Worker is so important. She is able to put them together and they get a sense of being part of a group, and it is a big enough group. It creates hassles for them, but they also have a sense of belonging. There are two sides of the coin. But it is important for them to have this space and sense of belonging, someone who knows a bit about what they are experiencing and knows their family so that they have that bigger connection, which I am never going to get to (as a non-Aboriginal person). I understand that, and I support it and make it work for them. The students don't understand that I understand, but I do, at least to some extent.

I am still really getting my head around all of this stuff; I haven't been at it very long. I really rely on the Aboriginal Education Worker to help guide me (HS I3).

The teacher commented that she was still very much learning, and that she was reflecting on new information while talking it through.

The importance of Aboriginal culture and identity

The Windsor Gardens Vocational College as a whole actively encouraged Aboriginal students to embrace their Aboriginality, and this was reinforced by the Aboriginal Education Worker who was a positive role model. She showed me the 'AEW Room' filled with posters of local, state and national Aboriginal people succeeding in all areas of life, education, sports, politics and

community. In a central space was a large map of Indigenous Australia with student's names pinned to specific communities of origin. She explained the significance of the map and the posters;

Before I put the map of Aboriginal places on the wall no one spoke much about where they came from. Then once I put it up there and my daughter and I put where we came from others put up where they are from. A lot of the kids are fair and did not talk much about their heritage. They got interested and went home and asked more about it. I use my daughter as a tool; the other kids look to her as a role model. I missed out on my own culture and now I am making up for it, sharing information, taking about family and working at connections. We talk about family and culture a lot. I am passionate about it, I encourage them. I say you are Aboriginal and it is Ok to be proud of it. There is nothing to be ashamed of, being Aboriginal. It is about identity and respect.

Some of the parents didn't want their kids to identify as Aboriginal, but now the kids wander into the AEW room here with the other kids. They are choosing to identify themselves as Aboriginal. People are acknowledging it now and not being ashamed. This is a big change from when I was young.

The school is really supportive. We celebrate NAIDOC week and reconciliation week. I work with the ESL (English as Second Language) teacher and the Aboriginal students together. We share cultural stuff and write for the school magazine. Now with excursions a lot of non-Aboriginal kids want to come which is great for reconciliation. They come in the room here too, and they are all welcome. The Nunga kids are not allowed to be discriminating either; I won't let them be. I tell them to treat the others as they would like to be treated themselves (HS I1).

Each of the times I visited the Aboriginal Education Worker I observed diverse groups of students speaking with her, calling out or smiling and waving to her.

One of the non-Aboriginal co-researchers noted that different young Aboriginal people reacted differently in relation to their Aboriginality. She said;

I think some of them are into it (culture). They speak it, know the stories and get involved. Others have been burnt by it and don't want a bar of it. It is funny; I have noticed that the dark Aboriginal kids who can be easily identified as Aboriginal take it for granted. It is the lighter Aboriginal kids who tend to fight more for their Aboriginality. I wonder if it is about their own culture's acceptance of them (HS I4).

This perception added another aspect to those discussed by the AEW about Aboriginal young people identifying or not as Aboriginal.

The needs of young Aboriginal women who are profoundly deaf

One of the teachers who worked with profoundly deaf Aboriginal students spoke of her realisation that many of these Aboriginal students were more connected with other deaf students than with their own cultural group because they had not been able to communicate with hearing people. She explained that when she took one young woman to some community events, it changed her understanding and connection and now she often goes to community events. This young Aboriginal woman's grandmother had come and asked her to help her grand daughter to reconnect with their culture. When I asked what she did to support this process she said that she promoted the event to the young woman, offered to go with her as a supportive adult and helped her to become involved.

The teacher went on to say;

Taking the young Aboriginal woman to events opened it up to the rest of the deaf community as well. Now it is an annual event and the whole centre for hearing impaired go to events like Sorry Day as part of their curriculum. Aboriginal and non-Aboriginal kids together and this has been really good; it has led to greater support and celebration of Aboriginal culture (HS I5).

She also saw this linking with the broader emphasis on breaking down barriers by including non-Aboriginal students in Aboriginal events.

In discussing the importance of culture this teacher said that she saw that when students were supported in being proud of their culture, and to share and

celebrate it with others, they flourished. *It makes it Ok to be Aboriginal.* She went on to explain that in the past there had been a, ‘*serious clash of culture between English as second language (ESL) and Aboriginal kids*’ and that the school had a policy of encouraging people to celebrate their own and others culture. They had a cultural event each term, and encouraged students to connect with their similarities as well as celebrate and respect their diversity.

The significant role of the Aboriginal Education Officer

Four of the five co-researchers identified the Aboriginal Education Worker as the most significant influence in supporting the Aboriginal students at their high school. In turn, her work with students was supported by a wider team of teachers, youth workers and counsellors. The employment of the Aboriginal Education Worker had seen the school suspension rate for Aboriginal students dropping significantly, enrolments of new Aboriginal students rising, and completion of higher year levels improving (HS I 1-5). The Aboriginal Education Worker discussed her role as increasing young Aboriginal people’s connection and access to the school. She had a very positive outlook and one of her first statements in her interview was;

I am really proud of all the kids coming in and there are another ten coming next year. I find that the Aboriginal kids support each other in school and through life (HS I1).

She went on to describe young Aboriginal women as *strong, independent young women who end up being positive role models.* She explained that;

When I first came to the school I said we were a team that needed to work together and support each other and they do that. They show respect and not fighting. If the boys have an incident and get all worked up the girls walk in there calmly and talk about it and settle it down. If the year nine girls get involved with a bitchy thing, the older girls will come in and say don’t get involved in this and sort it out. It is a cultural thing; the older girls are a big sister and role model. They all look after each other. There is not much discrimination or harassment in the school. The school is really supportive. (HS I1)

She identified the importance of community connection and support from families. Over time a strong community-school link had developed and she described a common goal with community as *we want to make the young ones strong and respectful.*

The need for stability and continuity

Maintaining a sense of continuity was another aspect that most of the education staff raised. The Aboriginal Education Worker identified that;

...students found change really unsettling and that with each new teacher and routine students became unsettled and there were issues until everyone felt settled again (HS1).

She saw it important that the older Aboriginal girls take a big sister and role model position, helping to smooth the way for girls through their changes. Supportive staff members and good systems were also vital and had resulted in a dramatic decrease in black/white conflicts. Staff members actively monitored what was happening socially in the school, whether arguments and fights were increasing, and if so they put a range of strategies in place such as harmony days, diversity celebrations and supporting friendships across cultures.

Anger, hate, friendships and reconciliation

Some co-researchers discussed the deep dislike, distrust or hatred that some Aboriginal students had for white education staff members. One said;

There are blockers; one of the main ones is when Aboriginal kids won't give you a change because you are white. Intergenerational hatred of white people, particularly white people in authority is still pushed on to the young ones, and then they start off hating you, before they even get to know you.

I try really hard to name the behaviour that is offensive. Sometimes the kids react really angrily and say 'you just say that because I am black', and I say no I am saying that because your behaviour is inappropriate, it is not about your cultural background (HS I4).

She went on to say that;

...many Aboriginal kids tended to fight rather than negotiate. They immediately put up a wall and escalate the issues. You can ask them a simple question and have a huge angry response (HS I4).

The Aboriginal Education Worker also identified issues related to anger and conflict and spoke of providing a space for students to settle and be calm. She saw the need for health and healing, to help people get rid of negative things and feelings. She identified that;

...many Aboriginal families have issues like welfare and problems that carry on through the generations. Link up and finding lost ones is really important.

It is important to look at the issues under the issue. Discrimination is anger based. Anger with white workers is linked to the Stolen Generation. Welfare workers get a reaction; there is still a lot of negativity about them. Police are the other ones. People's reactions are still scared and hurt. Even little kids run when they see police. There is a lot to work through.

It is important to sit and talk, to interact and respect each other, to bring culture back, to connect and learn more from the Elders (HS I1).

These two responses discuss the same issues from different perspectives. The first a reaction to angry students, and the second by the Aboriginal Education Worker who perhaps used a Dadirri type process, to seek to understand the issues behind the issues - which she connected to colonising actions such as the removal of children during the Stolen Generations. She indicated that the ramifications of colonising actions continue to play out in the school and wider social environment today. These were countered by the development of friendships and reconciliation activities.

All of those interviewed discussed the importance of friendships within and beyond Aboriginal groups, and said that the high school took an active role in supporting and encouraging friendships between Young Aboriginal women and wider inter- cultural friendship circles. Staff members reflected that five to ten years ago young Aboriginal women mainly had friendship circles with other young Aboriginal people, but now there were friendship circles that

included both Aboriginal and non-Aboriginal young people. One teacher said *it is important that they have positive relationships with white people, and often this starts with friendships with their peers* (HS I4). In many ways the school setting was a place where Aboriginal students could practise making wider friendships in preparation for entering the work force and the adult world.

One young woman who had left school and was now working, reflected on the difficulties she experienced initially in making non-Aboriginal friends as a young Aboriginal woman in a school with few other Aboriginal students. Below is a portion of our interview discussion that highlights (more effectively though our conversational style) her experiences⁵⁸.

She said;

I think that one thing when Aboriginal girls and non - Indigenous girls get together is that they look for the negative. Always the negative comes first and then they find the positives in people. But it is always the negative first. People hang back and it is always the discrimination being thrown on the table first. They say "This black person said this to me the other day" or "these black people were drunk". And I think, well I was not that black person you saw that was drunk on the street, or that person who swore at you. What, you don't think I get that too, that kind of thing? How is it that one Aboriginal girl walking into a room gets that? But if they (the non Aboriginal girls) can overcome the negative and look at the positives it is alright.

So do you find that in most places that you go that people see you as an Aboriginal person first, and then as a person? (JK)

Yep. All the time.

And what would you prefer? (JK)

Me ... I am a person before I am an Aboriginal. If you say something back that is discriminating of course I am going to get offended, but if you said it in a way that wasn't discriminating, I wouldn't be offended. But it is always colour first, and then the rest.

⁵⁸ This also provides an example of the conversation style used in many of the interviews.

Does that change as a friendship develops? Does something happen as a friendship develops between people? (JK)

I think the friendship becomes stronger, once they find out who you are. And then they are more open to what other people are like and what the world is like. I have friends from many different nations; everyone has different types of discrimination too.

The young woman also discussed that she did not automatically slot into friendships with Traditional Young Aboriginal women who came to Adelaide for schooling. She said;

Traditional people have been brought up to speak language and all that stuff. And there is a certain life style that they live and the rules that they follow, where as we don't really have any of that. We are kind of mingling with the non-Aboriginal community and we follow what they do.

She found it *funny and bizarre* that non-Aboriginal people expected her to have things in common with all other Aboriginal people, when there were so many different expressions of culture and identity in Aboriginal communities across Australia. She said;

I don't assume you light skinned people are all the same. (YAW 1)

This was a clear reminder of how Young Aboriginal women are 'Othered'.

Health

When co-researchers discussed the health and well-being needs for young Aboriginal women there were a range of responses. One said;

It is important to have support to keep healthy so that they can access curriculum. For example we had one young woman with diabetes and we needed to get that under control so that she could concentrate and do her school work. If kids are not well or they are worried they cannot connect at school (HS I5)

In addition to physical health she discussed the need for general sex education and improved access to health services.

Another co-researcher prioritised health issues relating to *pregnancy, rape, drug and alcohol issues, caring for younger siblings* (HS I4), and another

identified *unsafe partying and risk taking behaviours* as a major health concern (HS I3).

All co-researchers spoke about issues related to access, in that it was difficult for young women using health services for the first time, and that some had concerns about confidentiality, the stigma of attending a sexual health clinic and/or difficulty getting there. One participant explained that some of the students rarely caught buses into the city, and so city youth services were largely inaccessible for them. Bus services across suburbs were minimal, and so being able to access services locally was of benefit, as long as it could be done confidentially. Our professional experiences within Shine SA sexual health clinics were that young Aboriginal women tend to first come with friends and sometimes with relatives like a mother, auntie, grandmother, sister or cousin. Sometimes they come with a student counsellor or youth worker. Very rarely do they come alone (reflections on ten years of my clinical service).

Ways forward

When discussing possible ways that school based education and health services could work together, all five co-researchers were in favour of closer working relationships between the two sectors. They indicated that this would help young Aboriginal women get to know health staff, increasing the probability of young Aboriginal women attending these services if they already knew someone there.

There was also general support for peer support programs as an effective strategy in improving young Aboriginal women's health and well-being. One teacher said that peer support programs were the most important aspect of her teaching career. She described peer support as;

Working alongside them as they support each other to make a difference in their lives; the content is not life changing, the process, the increase in confidence is. It is important to support them, train them up, and help them develop skills that will enable them to work in a wider range of environments.

By tapping into culture, tapping into cultural ways, telling the older ones who will pass it onto the younger ones, practising positive relationships, communication and connecting with each other, having a preparedness to share knowledge and space (HS I4).

The five co-researchers were all interested in looking at ways that peer support could be incorporated within health/ education programs. Three of the co-researchers subsequently became actively involved as co-researchers in joint health/education programs over the next year.

Collaborative action between health and education sectors

Taking action

When health and education staff members met to discuss programs they could implement together, they agreed pragmatically that one event per school term (a period of three months) was possible with the resources available.

Term 1, 2006 - Aboriginal women's health day

The Aboriginal health team were preparing for the first Aboriginal Women's Health Day in February 2006 and invited the young Aboriginal women to attend. One of the Aboriginal health co-researchers consulted the Aboriginal Education Worker about what the young women would be most interested in. The Aboriginal Education Worker in turn spoke with the young women and said they were happy to come along and see what was available. The women's health day was the first time that health staff, education staff, young Aboriginal women and their friends met for the first time. As discussed by education co-researchers previously, the young Aboriginal women were encouraged to bring some of their non-Aboriginal friends to the event.

As discussed in Collaboration Area Two, the Aboriginal Women's Health Day provided a culturally safe, women only, intergenerational space where Aboriginal women (and their friends) could learn and exchange information about women's health and well-being. The young women became involved in health promotion and fun activities, and met with many community members.

The Aboriginal Education Worker, teacher/counsellor and hearing interpreter came with the young women, supporting them and joining in activities.

Evaluation – looking, listening, thinking and discussing again

Feedback via evaluation forms and verbal feedback by education staff/co-researchers revealed that the young Aboriginal women *really enjoyed the day, learning and sharing alongside the other women* (HS D2). The school staff recognised that the activity enabled the young women to increase their knowledge about health and well-being, and helped them to become familiar with local services and health staff in non-threatening ways. The young women and school staff were interested in further programs, and the education co-researchers asked if something could take place at the school in the next term, as gaining consent to leave the school and arranging leave from lessons was a complex and lengthy process. This request was taken to the Aboriginal Outreach Health Service management by health co-researchers and the health manager was able to secure funding to support a creative program within the school. Health and education management got together to discuss the possibilities.

Term 2, 2006 – Leadership program

In term two, a life coaching/media/leadership program was facilitated by an experienced non-Aboriginal youth worker/life coach and an Aboriginal film maker at the school. The program ran one day a week for ten weeks, and young Aboriginal women were released from other classes to attend. They learnt about leadership, film making, well-being, strength and celebration of culture and womanhood. Members of the Aboriginal health team came each week to discuss a health topic such as diabetes, asthma, nutrition and healthy weight, sharing knowledge and building relationships. This enabled health promotion and information sharing to be part of the program (albeit one way knowledge sharing). At the end of the program, the young Aboriginal women were all presented with an A3 booklet recording their artwork, journey and shared knowledge.

Education co-researchers expressed mixed feelings about the program from an education perspective, questioning how much learning took place when a large

amount of time involved listening and colouring in mandalas, and that the anticipated video was not produced when the Aboriginal film maker had to suddenly go interstate for sorry business (HS D4). The high school management remained supportive of the program throughout.

The Aboriginal Education Worker, who arguably was in closest contact with the young women, felt that the course was very positive and significant in increasing the young women's self confidence. Looking back at the end of the year she said she could definitely see a difference in the young women who attended. She also said there was a great advantage in the young Aboriginal women being able to meet various health professionals and that it would increase their comfort in going to see such workers in clinics. Some of the young women did attend various services following the program. Also in her role as AEW, she found it useful to have updated information about women's health and the services available.

Two education co-researchers noted that the hearing impaired students particularly enjoyed the visual art and camera usage. As one of them said *and who knows where that could lead. It has opened up another whole avenue of options for them* (HS D 7). The health staff involved in the program viewed it very positively and held it up as a model of practice that was later used for older women in the Aboriginal Outreach Health Service (AHS D9).

Term 3, 2006 - Young Aboriginal women's get together

Toward the end of term two, health and education co-researchers and I were talking through how best to evaluate our collaborative programs and build on the strengths. While attending a primary health care conference I spoke at length to a youth worker from a rural regional centre about the programs we were involved in and the difficulty we were experiencing in evaluating them in ways that enabled young women's voices to be heard, and that were interesting and meaningful for them. The youth worker said that she also needed to evaluate programs she was working with, and that the young women she was working with were very interested in meeting other young Aboriginal women. By the end of the conference we had begun to consider the idea of bringing the

two groups together, to share and evaluate their programs with each other, if they were interested.

On our return home we both talked with the young women, program coordinators and co-researchers to see if they thought the idea had merit (*think and discuss*). Everyone agreed it could be interesting and fun, and the rural youth worker and I became key contacts within a wider collaborative approach. Using email and phone conversations we put everyone's priorities, needs and ideas together and sought creative ways to meet most of them. We had two Aboriginal youth programs that needed to be evaluated. There were two groups of young Aboriginal women who were interested in meeting others and sharing ideas. The youth worker had just completed the Shine SA SE&X (sexual health) course and needed to undertake the practical part of her assignment. The young women from both groups had expressed an interest in knowing more about sexual health. Using flexible Ganma thinking, we set about planning an interactive, fun, culturally safe event that could encompass all of this. All involved agreed that it would be good to meet on neutral ground and the Aboriginal Outreach Health Service was chosen as the site of choice. Health staff and management offered to provide lunch, the local high school students would be the hosts, supported by the Aboriginal and Education co-researchers, and the young regional women would be transported the 100kms by youth workers.

The day went mostly as planned, with a few last minute changes. The young women from the high school came over early and worked with health and education staff to set up the group room. When the young regional women arrived, everyone had morning tea and then sat in a big circle to introduce themselves to one other. The oldest of the Windsor Gardens students welcomed the others and introduced their programs. She was hearing impaired and did this with the support of the sign teacher/interpreter. Both groups of young women shared details about the programs they had been involved in and swapped stories and resources. The visiting young women performed a hip hop dance that they had learned as part of their program and which they were now performing at public events in their regional centres.

The group then entered into smaller group discussion around tables with ideas recorded on butcher's paper. These two activities became the basis of the formal evaluation of the two programs. After lunch, the youth worker then provided a sexual health session while I evaluated her as an accredited Shine SA evaluator. Following this there was social time over afternoon tea. The young women were enjoying each others company and did not want to leave at the end.

When evaluated, it was found that this event was highly successful and well received by all involved. The young women enjoyed meeting each other and hearing about each other's programs, families and communities in a culturally safe and supportive environment. The young women discussed their differing communities and how friendships and kinship occurred in both.

The education staff found the day very positive. They were particularly excited for the oldest student who was hearing impaired and had spontaneously taken a leadership role with the aid of the sign interpreter. As the oldest of the young woman present, this was her cultural responsibility and right, and they said it was significant that she took this opportunity as she was often very quiet. They ensured that her role was included in her school academic assessment⁵⁹.

Both health and education co-researchers agreed that by working collaboratively with a common goal we had managed to meet a wide range of needs and agendas. We had expended minimal energy, opened the space for the young women to take leadership, and a positive and effective day of social, physical, mental, emotional, spiritual and cultural well-being was created.

Everyone involved enjoyed the day. Workers from youth, education and health sectors were able to network and support each other, and the young women were able to meet other young people and co-host the event. It was a day of cultural safety and knowledge sharing across many levels. People took the opportunity to try out new roles, ways of interacting and public speaking. It was also the most enjoyable way of evaluating a program that we had all been involved in.

⁵⁹ One of the teachers noted that this one of the advantages of having teachers present was that they could take observations like this back and put them into the education system for the benefit of the young women – ie in this case to improve the young woman's academic record.

Over time, unexpected outcomes became apparent. The Aboriginal Education Worker said that some of the young women had met again at the Royal Adelaide Show and deepened their friendships. One of the Aboriginal Health staff members became very interested in working with young Aboriginal women as a result of her involvement in the day, and went on to study a youth education course and continued her work with young people.

Dance

The other unexpected outcome was that the young Aboriginal women at Windsor Gardens became inspired with the idea of learning a dance themselves. They were very impressed with the hip hop dance performed by the regional young Aboriginal women and wished to learn a similar dance themselves that they could then perform. The Aboriginal Education Worker and teachers supported them to get together and plan what they would like, write a proposal, seek the support of the principle, and then contact different agencies to see who could work with them. In the interim, they began meeting each week and creating their own dance. One of the Aboriginal health workers joined them when she was able to (until she was returned to reception duties). This self directed and supported process was a time of capacity building and skills development for the young women.

The young women and the Aboriginal Education Worker described dance as being more than just a recreational activity. The young women saw dancing as a fun interactive activity that could help them to get fit and be positive role models for other younger women. School staff saw the creation of a dance group as an opportunity for young Aboriginal women to build their self confidence, gain organisational skills and promote positive images of young Aboriginal women. One said;

It combines two important things, culture and pride. Girls get into dance and it increases their confidence. This increases their strength, both together and alone. A lot of kids have stepped up and supported this dance. Some don't want to actually dance, but they are supporting the idea. They are doing the background work, phone calls, and organisation. It is increasing all of their confidence (HS I 2).

Aboriginal health team co-researchers recognised dance as a healthy activity that would promote fitness, self esteem and positive identity and supported the young women as best they could. They recognised dance as *a more energetic style of art and craft* as well as *a positive step forward in improving self confidence*. One worker added;

if they can get the confidence to get up and dance in front of strangers, they are more likely to have the confidence to negotiate safe and positive relationships (HS D8).

Term 4, 2006 -Aboriginal women's health day

In term four, a second Aboriginal women's health day was held at the Aboriginal Outreach Health Service and the young women were invited to attend. Health staff took the opportunity to follow up some of their suggestions from the first Aboriginal Women's Health Day and the young women's get together. The young women once again joined in the activities, learning and sharing alongside the other women who welcomed them once again.

Term 1, 2007 - Sexual Health Awareness Week

In late 2006 we began to collaboratively plan for a school based event on Valentines Day, 2007. Each year Shine SA launches Sexual Health Awareness Week (SHAW) with the theme Safety, Pleasure, Respect. Education co-researchers and students were interested in holding a SHAW event at the Windsor Gardens Vocational College. Staff members applied for the funding grant and three of the young Aboriginal women met with the Aboriginal Education Worker and health co-researchers to provide input into the planning. More often they had discussions prior to the meeting and the Aboriginal Education Worker relayed the information during the meeting as some of the young women were shy, particularly with the different health staff attending.

Unfortunately, the Aboriginal health team had less and less involvement in the planning and then no involvement on the day. The end of 2006 and beginning of 2007 was a time where there was no onsite health manager, there were many changes in staff, and clients with very complex and distressing needs had come flooding in. Communication between staff members was interrupted and a planned health promotion Bush Mechanics Stall did not occur on the day as

planned, which was very unfortunate as it was to be a central stall show casing Aboriginal health professionals. As a result of the Aboriginal Outreach Health Service 'crisis', I took on the role of co-coordinating the SHAW event so as not to leave the school in the lurch.

One of the teachers whose role involved working with and supporting Aboriginal students, and I, became the two key organisers of the event. I worked with external agencies using my community health knowledge and contacts, and she worked within the school. We planned a health promotion activity that could be structured to fit into the school agenda and timetable. A vision grew of an outdoor lesson and lunchtime 'market place' event involving visiting health, education and support services. Students could each receive a show bag, and walk from stall to stall asking questions at each stall and getting a paper stamped. There would be fun interactive activities as well as health information.

We spent a lot of time discussing with Aboriginal staff, students and community people how the day could support and promote Aboriginal people. In South Australia at the time there was very negative publicity about Aboriginal people, particularly Aboriginal young men. The police had begun 'Operation Mandrake', a strategy to 'stamp out Aboriginal youth gangs (Cappo 2007). Many Aboriginal people were speaking out about the negative effects of this strategy and the related media hype was having on their young men. Aboriginal people were becoming blamed for crimes that they did not commit. One mother discussed how her son was running along a roadside and was pulled over by police and then searched down to his underwear on the side of the road (Collaboration Area One FG4). Such strategies were worsening relationships between Aboriginal people, authorities and the wider community.

In response to these concerns, co-researchers decided that the SHAW event should have an underlying theme of promoting collaboration and positive images of Aboriginal people as significant and respected members of society. We asked each visiting agency to involve Aboriginal as well as non-Aboriginal staff to attend on the day. Two student bodies were involved with the planning of the event, the student events team and Aboriginal students. Their participation was advertised, and the event was viewed very favourably by

fellow students who enjoyed the longer lunch break and fun activities. Subtly we aimed to improve Aboriginal young men and women's image within the school.

Unfortunately the school did not receive the SHAW grant funding because the focus that year was on over 18 year olds, but the high school management continued to support the event regardless. This reflected the effective networking and collaborative work being done within the school over many months. Many teachers had interwoven the SHAW concepts of Safety, Pleasure and Respect into their curriculum. Many students were involved in setting up, welcoming and assisting visitors, catering, supporting stall holders and providing some stalls themselves.

The day went according to plan, with minor changes on the day. The newly developed outdoor area looked fantastic with new bright sunshades and red hearts attached to many surfaces. There were lots of free gifts and conversation. The red heart trail (needing to have the paper stamped at each stall and then get a prize) worked very well.

Services who attended included local council, drug and alcohol services, Red Cross First Aid and Save a Mate drug intervention strategy, university, research, and Aboriginal services, mental health, sexual health and youth health services. Many Aboriginal professionals attended, including one Aboriginal man who was a well known footballer. The teacher/co-researcher ensured that one of the young Aboriginal men had the role of showing this local football hero around, thus increasing his own status in the eyes of his peers. All stall holders, Aboriginal and non-Aboriginal, responded to the evaluations saying that they had found the day very worthwhile. Most of the 500 students who attended for up to three hours also voted the day a success.

When we met as co-researchers to evaluate the day we reflected that it had been very successful. The less successful aspects were that we had invited the police to attend and perhaps provide a BBQ, but unfortunately that was not able to be arranged in time. This was unfortunately a missed opportunity for positive relationship building, for a major police station was situated across the road from the school. Also challenging was the withdrawal of the Aboriginal Health Team who was to have a central role in the planning and facilitation of

the day. There was general understanding that this was not intentional but the result of staff changes and challenges, but it did mark the end of an active collaborative partnership between the school and the health service.

Also in term one 2007 was the planned SE&X youth worker training. Plans in 2006 involved arrangements for four high school students to attend as part of their year eleven and twelve studies. The course is nationally accredited and they would get SACE points. One of those interested in participating was a young Aboriginal man who was hearing impaired, and this would require the employment of a sign interpreter. Early discussions were that perhaps the course could be the start of a wider peer education program.

Unfortunately a week before the course was to run (having had the dates changed once already) the school rang to say that neither staff nor students were able to be released as the day chosen for the course was too disruptive for their curriculum, and could the day be changed again. Unfortunately that was not possible for the health services staff and the school withdrew from the program. As this was the end of my PAR I was not able to follow up with other options, but I did refer the school on to the sexual health agency for further discussion. Happily, when I was providing a contraceptive / STI discussion to a group of community services students as part of my community health work, I realised one of them was the young Aboriginal man who was interested in the SE&X course, and he was able to pick up some information with the assistance of a sign interpreter. He may yet do the course.

The significance of our collaborative research

Co-researcher reflections

At the end of our collaboration, I asked co-researchers how effective our research together had been in their opinion. The Aboriginal Education Worker who was arguably the person most connected with the young women, said it was a useful program that introduced new ideas, built networks between *'the girls'*, the health service and the school, and also increased everyone's knowledge of health concerns and looking after oneself. Other education staff discussed that the collaboration had increased their and the young women's knowledge of health issues and how to access services.

Stakeholder reflections

Elder Aboriginal women were particularly happy about the young women's involvement in Women's Health Days and the other young women specific programs, saying that there is need for *multigenerational* as well as *young people only* spaces for women's health discussions. Aboriginal health staff reflected that the activities in this Collaboration Area helped the health service to connect with young Aboriginal women in the high school. Our collaboration had enabled them to prioritise and organise programs and activities for young women. They reflected that since this research project finished there had been no more activities between the school and Aboriginal Outreach Health Services.

The young Aboriginal women indicated via the Aboriginal Education Worker that the program had been worthwhile, although they would have preferred more action and involvement in the decisions being made about the over all program. They advised that if anyone was thinking of working with the young Aboriginal women in their school, they should talk with the AEW and the older *Aboriginal girls* who would act as spokespeople for the *younger girls*. As discussed at the beginning of this chapter, I had not prepared the research or ethics application to meet the needs of young women in schools, as originally I had planned to conduct the research at the community campus.

My reflections as a nurse/researcher

As a nurse /researcher I was challenged by not being able to work directly with the young Aboriginal women in this Collaboration Area. While I understood and supported the very important ethical reasons for this situation, I remained concerned that I was unable to directly elicit and record the young women's knowledge and opinions in the first person. With further reflection I have realised that this Collaboration Area process followed what often happened in practice; that health and education professionals get together to plan programs, with greater or lesser involvement of young people in top down approach.

Themes and discussion

In this section I discuss the findings from this Collaboration Area under the themes of knowledge sharing, working together and addressing issues. Although the themes and findings overlap this format provides a basic structure for this discussion.

Knowledge sharing

Aspects of knowledge sharing

In this Collaboration Area, two different aspects of knowledge sharing and collaboration occurred. Due to ethical constraints, I was unable to work directly with young Aboriginal women in schools as a researcher. Therefore, to collect data I worked closely with community members, parents, teachers and Aboriginal education and health workers and we discussed Aboriginal young women's needs from the perspective of those who care for, or work with them.

During school and health service based programs, the young Aboriginal women became directly involved in discussion meetings, actions and evaluation as program rather than research participants. I then was able to refer to the health and education evaluation reports which were de-identified program documents. Having thought deeply about this situation, I came to the conclusion that even if I had ethical clearance to work more closely with the young women, I would have needed to work closely alongside the Aboriginal Education Worker, Aboriginal health Workers, counselors and teachers. They would have been my cultural and relationship guides, teaching me how to work effectively with the young women.

Unlike my work with the Aboriginal community women, these young Aboriginal women and I had no prior relationship on which to build collaboration. As discussed by Matairea (2003) I would have needed more time to understand the young women's cultural and personal perspectives, and they would have needed more time to trust me enough to begin communicating effectively. In recognition that Aboriginal and young people's cultures are not immediately permeable, I would have needed to take much more time to interact. Working with education professionals enabled the process to speed

up, and still remain culturally safe for the young women involved. An adapted form of Ganma knowledge sharing facilitated by trusted people such as the Aboriginal Education Worker, enabled knowledge sharing and collaboration took place between the young women, the Aboriginal health service and myself.

Knowledge sharing between adults in this collaboration area was a simpler process. Aboriginal Elder women and parents, health and education professionals became involved in interviews and focus groups, discussing what they believed the needs and priorities for young Aboriginal women were. Specific issues were raised relating to ongoing effects of colonisation, discrimination and exclusions and how these affected young people today. The education professionals discussed specific strategies introduced by the school to address these issues.

Working together

Collaboration across sectors

This Collaboration Area explored how to create effective collaborative programs across services. Co-researchers identified the importance of involving at least one representative from each agency early and preferably throughout the planning process. This person could raise organisational and personal priorities and co-create a collaborative goal across organisations and disciplines. We discovered the importance of including management personnel early in the planning process to ensure organisational support. Our collaborative and responsive PAR cycle of Look and Listen, Think and Discuss and Take Action, underpinned by Ganma democratic knowledge sharing and Dadirri deep listening, provided the means for effective work across sectors. It enabled us to meet a diverse array of needs and priorities in creative and flexible ways. For example, the young Aboriginal women's get together enabled one youth worker to finish her sexual health training, enabled Aboriginal health programs to be evaluated creatively, increased the young Aboriginal women's knowledge of sexual health, widened friendship circles, improved networking across agencies, provided positive role models and promoted local Aboriginal health services.

Enacting comprehensive primary health care

By working across sectors, co-researchers were better able to embody the principles of comprehensive primary health care. As advised in the Alma Ata Declaration (World Health Organisation 1978), comprehensive PHC involves a wider approach to improving social determinants of people's health. By working together, health and education services were able to support young Aboriginal women toward remaining healthy and making choices that would enable them to remain in school, seek employment, have positive self image, become leaders and break the poverty cycle. Following the women's health day some of the young women attended health service clinics to access contraception to enable them to finish their schooling without fear of pregnancy. This outcome was fully supported by parents and Elders.

Sustainable programs, or people as sustainable links/networks

At the end of this program, the connection between the school and health service staff members remained, but no specific young Aboriginal women's programs continued. Without someone to stimulate the collaboration, such program initiatives became lost amongst other priorities in health and education. The Aboriginal Education Worker was very pragmatic about this when I spoke to her about it a year later, saying that she had found workers in the local council who were available and were working with the students. She herself became the sustainable link, enabling the students to connect with a range of services. In this way, the Gilles Plains Aboriginal Outreach Health Service became one option in a wider pool of services, and she became the constant contact person. Her networking approach enabled disjointed programs and services appear connected, and for the young women to access services that helped counter intergenerational colonisation and discrimination effects.

Addressing issues***Issues for the next generation of Aboriginal women***

Health and education professionals, older Aboriginal community women and parents all identified the ongoing impact of colonisation and discrimination for this next generation of Aboriginal women. They discussed the high levels of

grief and loss that young Aboriginal women and men deal with from an early age, and the fact that there are less Aboriginal adults to support higher numbers of Aboriginal children. Experiences of intergenerational trauma, lower social determinants of health and lower life expectancy among family members were experienced alongside higher levels of ill health, suicide and health comorbidities affecting the way young people view life and make decisions. Education staff identified that many young Aboriginal women often needed *a little more support* to achieve the same outcomes as their non-Aboriginal peers. This was thought to be linked to personal, family and community experiences of discrimination, colonisation acts and exclusion on a daily basis. Both Aboriginal and non-Aboriginal co-researchers identified that while mainstream Australia can ignore colonisation, young Aboriginal people cannot, because it makes up the fabric of their daily lives.

To counter this disadvantage, the school set in place specific strategies to support young Aboriginal women through to achieve higher levels of schooling. They were encouraged to develop wider friendship circles, engage with employment and training opportunities and envision a positive future. By improving young Aboriginal women's education and employment outcomes, it was hoped that the young women would be able to improve their social determinants of health and avoid the health impacts of poverty.

Our collaborative activities aimed to further enhance young women's health and wellbeing, self image and ambitions by utilising and furthering strategies that worked. For example, the young women were invited to bring a non-Aboriginal friend to the Aboriginal Women's Health Day to further understanding and reconciliation across cultures. At the school expo we specifically invited Aboriginal workers from each agency to be involved, to promote positive Aboriginal role models in health, education, sport, healing and tertiary studies. Their involvement challenged colonising stereotypes of Aboriginal people at a time when Aboriginal communities were feeling particularly vulnerable due to negative media portrayal of Aboriginal men and young men.

Summing up

Collaboration Area Three has focused on ways that health and education sectors can work together to improve young Aboriginal women's access to health information, services and well-being. It responded to concerns raised by Aboriginal Elder women and mothers that young women may not be receiving important women's health information and encouragement to attend health services. Health professionals were keen to work with young Aboriginal women in comprehensive primary health care programs in conjunction with school staff. They identified that they saw very few young Aboriginal women in the clinic who were not *physically ill or already pregnant*. Education professionals recognised the importance of collaborative relationships between the young Aboriginal women, the school and health service to ensure the young women had timely health information and access. I was unable to work directly with young Aboriginal women at the school as a researcher; rather I became indirectly involved by supporting health and education co-researchers to work together collaboratively.

This research highlighted that issues related to colonisation, discrimination, inequities, grief and loss continued to negatively impact on many young Aboriginal women's lives, education, health and well being. Most co-researchers identified the need for young Aboriginal women to be supported to develop a positive Aboriginal identity with strong links to family and culture, although some teachers questioned the academic benefits and challenges for young women who connect strongly with their Aboriginal families and cultures. The vital role of central support people such the Aboriginal Education Worker (AEW) was highlighted. The AEW was repeatedly identified by all co-researchers as someone who understood the deeper issues and supported students and their families in culturally safe ways. In the next chapter I discuss how co-researchers and I worked to improve positive collaboration across wider sectors in Australia by co-planning an action research action learning conference embedded in Aboriginal preferred ways of knowing and doing.

Chapter 10 Collaboration Area Four – A National Action Learning Action Research Conference

Overview

This chapter discusses the process of planning, implementing and evaluating a collaborative de-colonising action research and action learning conference embedded in Aboriginal preferred ways of knowing and doing. Together Aboriginal and non Aboriginal co-researchers and I planned to create opportunities where Aboriginal people's experiences and knowledge could be heard, valued and respected. In addition, this collaboration and chapter responds to my personal concerns regarding the ethics of writing this thesis and presenting my account of our collaborative research, without first creating spaces where Aboriginal co-researchers could share their own knowledge and perspectives with a wider audience. A group of Aboriginal and non-Aboriginal researchers, academics, educators, project managers and other interested people came together to co-plan and co-host a national conference in Adelaide. We agreed on the title *Moving Forward Together* and focused on both the process and outcomes as equally important aspects of our collaboration.

Methods

The methods used in this Collaboration Area include collaborative planning meetings, recording minutes, email and phone communications, individual evaluation via email, and collective analysis, interpretation, decision making and evaluation.

Co-researcher selection

Many people were invited to become involved in this collaboration project. Those positioned as co-researchers were people who had the time and energy to become involved with the conference planning process. Co-researchers came from the main three Adelaide universities (University of Adelaide; Flinders University and University of South Australia); the Aboriginal Health Council of SA; Flinders Aboriginal Health Research Unit (FAHRU); the Co-

operative Research Centre for Aboriginal Health (CRCAH); the Co-operative Research Centre for Desert Knowledge; Action Research Action Learning Association (ALARA) and Tauondi College. Four co-researchers were Aboriginal, the remaining seven were non-Aboriginal. Some co-researchers were involved in more than one of the organisations listed above. Co-researchers became the central group of South Australian's planning the conference in collaboration with the national action research and action learning body and named themselves Team SA. In this research project I am positioned as one of the main co-researchers and co-facilitators and have written myself into the text to reflect this active role.

Stakeholder selection

Stakeholders were diverse and included; co-researchers and stakeholders from this research study, Aboriginal and non-Aboriginal community members and professionals from across Australia, health, education and environment professionals, students, academics, researchers, managers, policy makers and politicians. Many of these people became involved in the conference as participants, sponsors, supporters or people who had read information disseminated regarding the conference.

Coding of data & naming co-researchers

Coding for confidentiality has been much less applicable in this Collaboration Area because most of the processes and people involved have been public and transparent. To demonstrate the friendliness and close collaborative relationships that permeated this process I have used first and last names of people central to the project, just as we did during the planning. Coding of data sources has involved identifying whether data came from Team SA⁶⁰ planning meetings, conference proceedings, evaluation and/ or individual evaluation sheets that I invited Team SA members to complete via email.

⁶⁰ The group of co-researchers who came together to plan, implement and evaluate the conference.

Recognising the need for wider knowledge sharing

I came to this research searching for spaces where Aboriginal and non-Aboriginal people can come together to discuss effective ways of moving forward together. As a non-Aboriginal nurse, I was never sure whether ‘Aboriginal health’ conferences and workshops were intended as spaces for *Aboriginal colleagues* to come together to discuss shared issues and experiences, or whether they were spaces for *Aboriginal and non-Aboriginal people working in the area of Aboriginal health* to come together. While I wished to be respectful of Aboriginal specific spaces in post-colonial Australia, I also felt the need to talk with a diverse group of Aboriginal and non-Aboriginal colleagues sharing ideas, challenges and strategies. During the community consultations and interviews I found that I was not the only person struggling to find such opportunities; many Aboriginal and non-Aboriginal colleagues and stakeholders also expressed a desire for knowledge sharing across a broad sector of practitioners, researchers, community people, policy makers and academics. Within my Masters research there were discussions with like minded groups, but less discussion between groups. I sought to find ways to share knowledge more broadly, in culturally safe and respectful ways.

The Elder Aboriginal women in the Aboriginal Women’s Reference Group spoke specifically about the importance of creating a ‘level playing field’ in which all knowledges were acknowledged and respected. They said;

It is about making that playing field level - the Western way of knowing is always wanting to be up here, and all the Aboriginal people’s way of knowing is put down there. We don’t want to be here or there, we just want a level playing field. So how do we get from here, to here (holding her two hands at different levels)? It is getting respect from up here, and meeting us on our own grounds. Having respect; doing it two-ways (Aboriginal Women's Reference Group 2005).

This viewpoint, combined with my own concerns about the dominance of Western knowledge in post-colonial health systems, led to this research and thesis being based on concepts of democratic knowledge sharing as described in Ganma by the Yolngu people (Yunggirringa & Garnggulkpuy 2007), Freire

(1972) and Belenky and colleagues (1973) Together, co-researchers and I developed a model of collaborative practice that allowed us to share power, knowledge and decision making as much as possible. We co-wrote and co-presented at conferences and workshops to ensure that our diverse and collaborative knowledge could be effectively shared with a wider audience, although at times we were constrained by time, setting and presentation style expectations (a ten minute time slot with a ‘punchy’ power point presentation).

When it came to writing this thesis however, I was faced with a dilemma. This thesis, by its very nature, is my own work. While academically this is acceptable and expected, as a white researcher guided by postcolonial feminism and the repeated stories of Aboriginal women colleagues and co-researchers, I became concerned that *my* (salt water) perspective of *our* collaborative process would inevitably be privileged. No matter how much I tried to include Aboriginal women’s and co-researchers’ voices, and asked their opinions, the dominant writing influence, the decisions underpinning how this research would be written, would always be mine. As I reflected on this I felt a growing need to create spaces where co-researchers could actively discuss their views with others in a range of learning and sharing styles of their choice, before I finished writing this thesis. My thesis could then be another form of knowledge sharing about this research, rather than the only and dominant form.

Envisioning a knowledge sharing conference

Recognising the significance that the Aboriginal community women in Collaboration Area One placed on their involvement in co-presenting at conferences and workshops, I sought ways to further and extend this opportunity. One of the Aboriginal women mentoring me, Kim O Donnell, and I began to envision an event that could enable Aboriginal and non-Aboriginal, community and professional co-researchers and stakeholder to come together and share knowledge, regardless and regardless of culture, gender, English literacy, location and background. We imagined enacting Ganma more broadly across sectors of society, while addressing Aboriginal health research ethics and co researcher expectations of information sharing in real and pragmatic

ways. This would be an integral part of the research, rather than as an 'add on' once the research had finished.

Think and discuss

In a serendipitous moment, Kim O Donnell, Helen Murray (an experienced nurse researcher in Aboriginal health), and I met with Ernie Stringer in late 2006 to discuss action research and the complexities of our work in Aboriginal health. During our meeting, Ernie asked if we would like to host the next national Action Learning, Action Research Association (ALARA) conference in Adelaide the following year, in nine months time. ALARA is an international strategic network of people interested or involved in using approaches to transform a wide range of settings (ALARA 2007). When we asked what the parameters were, he indicated that there was an expectation that the conference would discuss action learning, action research and process management, with a focus on health, environment and education, but beyond that we could design the event to meet local preferences and priorities. While there was a possibility of a seeding grant, the conference would need to pay for itself. We three 'can do' people immediately recognised the opportunity to create the kind of knowledge sharing event that we had been discussing, and agreed to take up the challenge. We envisioned a forum where Aboriginal and non Aboriginal people could come together to discuss existing issues and positive ways of working together.

Calling a meeting of like minded people

Our first step was to invite other people who were interested in being involved. Over the next few months, a small but growing group of people met at the Aboriginal Health Council of South Australia, a central and 'neutral ground' for most of the agencies and universities involved. We purposely sought representatives (Aboriginal and non Aboriginal) from all three Adelaide universities, the Aboriginal Health Council of South Australia, and a range of health, education, environment, legal and welfare agencies. A wider group of practitioners and community members were interested but unable to attend due to other priorities. However each planning group member connected with a wider group of people and facilitated two-way knowledge sharing to and from

the central planning meetings (like spokes on a wheel with the meeting as the hub and the wider communities along the rim).

Together we developed a planning group that was non-hierarchical, based on democratic knowledge sharing, equality, respectfulness and open and transparent communication. Each person was recognised as bringing their unique knowledge, skills and expertise (fresh and salt water) that was shared in a large Ganma swirling pool. The resulting collective knowledge (foam) helped to create a unique and responsive conference. Kim O Donnell and I became the two main co-facilitators, with each planning group member taking on particular self appointed tasks. I became the link person between ALARA and the planning group. We decided we needed a snappy name after being described as a *loose collection of people*. We saw ourselves as a *dynamic group of people*, and named ourselves Team SA (Team SA meeting minutes November 2008). Team SA developed into a unique collaborative team where all participants became involved above and beyond usual work and personal commitments. We developed a *person centred* no blame, no guilt way of working so that if a team member was no longer able to complete a task, they let the team know and someone else who had time, energy and/or skills took over. We all recognised that each other had busy and complex lives with many personal, professional and family commitments.

Co-facilitating this emerging and constantly changing planning group toward a common goal (the people who could attend planning meetings often changed) was a challenging and exciting experience for Kim and I. We learned to hold the meetings and processes flexibly together, enabling room for creativity to emerge, while meeting deadlines and ALARA's agendas. We facilitated a mixture of face to face meetings, phone conversations and email communication. I was asked to join the ALARA management team to enable me to better understand their national expectations and resources.

Growing the vision – actively supporting Aboriginal preferred ways of knowing and doing

Together Team SA envisioned an action learning / action research conference embedded in Aboriginal preferred ways of knowing and doing. 2007 was the fortieth year since the National Referendum, and we felt this was a significant

time for reflection. Each person brought their priorities and visions for the conference as;

...highlighting action learning and action research as a worthwhile way of undertaking research generally, and more specifically in Indigenous contexts.

...promoting collaborative research activity, providing very valuable networking opportunities and, hopefully, being a mechanism to promote Indigenous ways of knowing and doing and to help reduce Indigenous people's concerns about bad research.

...boost the morale of Aboriginal leaders and entrepreneurs, giving them exposure and publications as respected scholars and researchers, in their own right.

...enable people to discover new ways of doing action research by talking together, to enmesh the boundaries of different disciplines and cultures.

Aboriginal people will feel empowered to do their own research and publish their own papers, changing the nature of research.

Generally all agreed on the importance of;

Networking, awareness raising and learning, skill development in action research, participants learning from each other, taking action after the conference. We wished to create a respectful space to listen and learn from others, and reflect on their own practice (Team SA meeting minutes September to November 2006).

From this collective vision, we formulated a vision of the conference which we put into an advanced notice flyer to describing the upcoming conference. It read;

Moving forward together

Enhancing the well-being of people and communities Through Action Research and Action Learning

Topic areas include education, environment, health and Aboriginal ways of knowing and doing

- ✿ A multi-disciplinary conference focussing on collaborative ways of knowing and experiencing action research and action learning.
- ✿ For community groups and services, workers, volunteers, researchers, professionals, educators, policymakers and managers
- ✿ An interactive conference with a range of themes, disciplines and learning, teaching and information sharing styles including:
 - Special interest yarning & discussion groups
 - Peer reviewed papers
 - Poster sessions
 - Meeting Place stalls

(Team SA November 2006)

Once our agreed vision was endorsed by ALARA management and executive, we began planning in earnest following our collaborative process of Look and Listen, Think and Discuss and Take Action individually and together, underpinned by concepts of Dadirri (deep respectful listening), Ganma (two-way learning and creating new knowledge), cultural safety, respect and social justice. These underlying beliefs were shared by most of us and led us to make specific decisions, as discussed below.

Keeping costs low

Team SA envisioned a conference that was accessible to a wide range of peoples regardless and regardful of income or financial circumstance. With no funding source other than the conference fees, this was a challenge. In the interests of inclusion and social justice, we argued for low registration fees and sought additional sponsorship to enable rural and remote people to attend. Team SA members spent considerable time and energy seeking, arranging and ensuring sponsorship through their networks to enable Aboriginal people from all over Australia to attend.

A culturally safe venue

We also spent a considerable energy debating which venue was most appropriate. To meet our social justice mandate, we needed a venue that was not expensive, was accessible via public transport, had low cost or free car

parking facilities. Ideally it would also have access to outside areas (particularly important for rural and remote people) and be reasonably near to accommodation. We preferred to invest in local rather than multinational organisations, and if possible enter into a two-way beneficial partnership with the venue organisation involved. After much consideration, we decided to hold the conference at Tauondi College.

Tauondi College is an Aboriginal Community College situated at Port Adelaide. Courses offering adult education including hospitality, community services, environmental and cultural tourism. Many Team SA members, myself included, had existing relationships with staff, management and/or students at Tauondi College. We also entered into a formal partnership with management. Interestingly, when reading Tauondi College promotional literature it said:

Our way, the Tauondi Way; where the salt water meets fresh.

- *Involving cultural teaching and learning processes which embrace and include land, sea, inland waterways spirit, body and mind.*
- *The sharing of a diversity of cultures in contemporary and traditional experiences and knowledges to create opportunities for life skills and life-long education.*
- *An exchange of learning through informal and formal situations and experiences such as role models and the sharing of understandings.* (Tauondi College 2008)

This vision complemented the collective vision that we held and became another serendipitous moment.

Receiving a sign

During our venue decision making process, we received a sign that confirmed for many Team SA members that Tauondi College was the right place to hold the conference. A small group of Team SA members were meeting at Tauondi College with management and guides to see if the venue was suitable in size, resources, room availability etc. When we walked into one of the rooms upstairs, Kim O Donnell saw a poster on the wall of her *old uncle*. She told us that this was the uncle who had been forced by white researchers to go with

them and tell them all of his cultural business, against his and his community's wishes (as discussed in the Ethics Chapter). One of the Tauondi guides spontaneously took the picture off the wall and gave it to her saying '*here, you have this, we have two of them*'. Kim was very appreciative. The next weekend she went back to her home country and related the encounter to the *old Aunties* (Elder women). They told her that *that is a sign that that is the right place for you to have the conference*. When Kim came back and shared this with us, many Team SA members (Aboriginal and non-Aboriginal) said that they found this very reassuring as they often look for a sign when setting up programs and projects, a message to indicate that what they are doing has approval or a serendipitous moment. For one Aboriginal Team SA member it was the turning point of their involvement; suddenly the conference became *real* because it was supported by ancestors. A few Team SA members found this event intriguing, and although they themselves did not seek such signs, they were respectful of what it meant for those who did, highlighting the cultural respect between team members.

The welcome & knowledge-sharing panel

Much discussion and care went into arranging the Traditional welcome to country and to Tauondi College. We juggled the political correctness of recognising a Kurna Elder representing their country, involving the chair of the board, and the president of ALARA. We chose to support cultural ways before organisational politics. Following concepts of social justice, equity and acknowledging all knowledges as equally important, we decided against having a key note speaker at our conference. A keynote speaker is usually paid a large amount of money and their knowledge is showcased as (possibly more) important and valid. In a move away from this, we envisaged starting the conference with a panel discussion that could set the tone for the conference. We invited eight people to be involved, two from health, education, environment and research. Each 'pair' consisted of an Aboriginal and non-Aboriginal person who discussed how they related to concepts of action learning/action research and collaboration. Our aim was that every person in the audience could relate to at least one panel member and what they were saying. Accordingly we had younger and older Aboriginal and non-Aboriginal

people, those working in communities and universities, health and education services.

For example, we invited Ricky Menta, an Aboriginal man from Central Australia who was working with Aboriginal communities in and around Alice Springs, and the Australian Football League, to reduce alcohol consumption and increase family involvement in sports, to share his knowledge. He was paired with Ernie Stringer, an experienced non-Aboriginal action researcher. Together they had 'a conversation' where they introduced each other and asked about each other's work. Through this conversation, the conference participants could hear and see the links drawn between the practical on the ground community based work Ricky was doing, and the theoretical concepts of PAR that Ernie works with and writes about.

Another pairing was Ngarrindjeri man George Trevorrow and University of South Australia ecologist Joan Gibbs. Together they discussed the collaborative program they have created that involves Joan bringing environmental students to the Coorong to assist with revegetation on Ngarrindjeri lands. They discussed how students learn about deep listening and two-way learning (similar to Dadirri and Ganma but the Ngarrindjeri people have their own terms). Students come back having learned much more than how to revegetate, they have learned how to work collaboratively and respectfully with Aboriginal peoples.

The program

The program reflected our intent of enabling a wide range of knowledge sharing and learning styles to be accommodated. There were short presentations and longer interactive sessions, workshops, a market place where people could meet and talk leisurely in smaller groups, healing and bush medicine, academic information, cultural tours, dance, music and art. When we originally wrote the program, we envisioned more time for networking and informal conversations. However, providing space for the diverse range of speakers to talk, and ensuring that we had enough numbers of presenters/attendees to make the conference financially sound, meant that some of this time was lost. There was also pressure for academic peer reviewed

presentations to be included as this was an expectation by many universities. The program can be seen in Appendix 10.

The conference as reality; moving forward together

Over one hundred people attended the conference from every state and territory in Australia, as well as one participant each from New Zealand and the United States of America. People came from urban, rural and remote areas, with approximately half identifying as Aboriginal and half as non-Aboriginal. Participants came from health, research, education, environment, policy, legal, information technology, management systems and community backgrounds. There were grass roots workers, community members, students, academics, Elders, experienced professionals and those new to a range of positions.

Tauondi staff and students, Team SA members and ALARA management worked together to host a comprehensive conference experience. Tauondi students were involved in catering, front desk and reception work as well as general support and resource provision. Aboriginal cultural guides and story tellers, dancers and artists worked alongside and in between the formal conference activities. The conference showcased the best that Tauondi has to offer.

Linking Gilles Plains co-researchers into the conference

One of the community women from Collaboration Area One, Rose Daniels and I co-presented a session discussing the importance of taking time to build respectful relationships that can then lead to meaningful collaborative research and action. Our joint presentation was very well received, and Rose stayed for the day talking with many other participants, sharing her knowledge and learning. One of the Aboriginal staff members assisted Rose with transport enabling her to come and enjoy the conference (CA4 E2).

Two of the Aboriginal health workers from Gilles Plains Aboriginal Health Outreach Health who attended the conference found listening to Aboriginal workers from across Australia inspiring and up lifting. They particularly enjoyed Dorothy Yunggirringa and Joanne Garnngulkpuy's (2007) presentation describing Yolngu Participatory Action Research. Using artwork

and stories these inspiring women discussed how their health service wove western research methods into local cultural and traditional ways to create a responsive program. As a result of the conference, one of the workers is considering further study in Aboriginal and/or participatory action research. She said that PAR seemed a positive way forward through the complexities of her work place (CA4 E3).

A collective from the Gilles Plains Community Campus co presented a session discussing collaborative practice. An Aboriginal Elder man, a nurse from Aboriginal health, the principal of the Gilles Plains Primary School and the nurse/manager of Gilles Plains community health services all came together to present the history of Gilles Plains and how they had developed collaborative practice across the campus. The co-writing of the presentation, as well as co-presenting further strengthened ties across the campus (CA4 E 4).

Look and listen again - Evaluating the conference

As part of the PAR process we invited all participants to evaluate the conference. Evaluation sheets were provided and completed individually or in small groups depending on preference, literacy level and time frames. As part of the conference we facilitated small group and larger group discussions regarding the conference, action research and action learning, and where to from here.

The highlights

The majority of people spoke of the value of learning through hearing about other people's real life experiences, and how this bridged the practice theory gap, or the '*will it really work*' question. The Yolgnu women's presentation was often mentioned as a good example of this. Others commented on the broad and wide range of action research and action learning styles discussed throughout the conference and how this gave them many choices to consider using themselves. Many spoke about the level of awareness, learning and sharing that was evident throughout the conference. Most enjoyed the atmosphere, environment, level of acceptance and flexibility. They appreciated the *generosity of spirit between participants and between speakers and*

participants. One described the conference as a *transformation* (Team SA Evaluation 2007)

Some Aboriginal participants said that for them the highlights were;

...viewing and balancing both worlds, meeting a lot of people working with action research and learning from each other's knowing. They said they could see the respect in tangible ways, between all the participants, and it was a safe environment, where I felt I could speak up and not feel embarrassed (Team SA Evaluation 2007).

Many discussed having increased their networks and finding new tools to help them in their communities and work. For some, the highlights were more personal and involved knowing that *there are people that do care, have understanding and knowledge*. This knowledge enabled them to *be brave and strong to stand firm, and to go forwards* (Team SA Evaluation 2007).

What people learned

When we asked what people had learned by attending the conference, they spoke of *being exposed to different applications of action learning and action research in health, education, town planning, etc, gaining increased insight into Indigenous ways of being and applying AR/AL ideas and method, and managing change in ways that ensure it is positive for us all* (Team SA Evaluation 2007). Many commented on the pragmatic, grounded discussions linked to deep philosophies. Some spoke of *self-awareness of deep prejudices and how deep it goes*. One group discussed *having actively listened and now being ready to change*. There was learning around *diversity and sameness, togetherness and inclusively*. Others said they now realised that *everyone's work should be celebrated*.

One spoke of the;

different energy/thinking/discussion /approach that emerged from the place in which the activities took place. Setting this conference in an Indigenous space has shaped this conference effectively.

Another said;

I have learnt how easy it is to think and learn and reflect on change and growth in a warm, receptive, flexible environment of this conference in this venue (Team SA Evaluation 2007).

Interestingly, the concept of respecting to and listening to Elders resonated particularly for interstate members of ALARA and they spoke of finding out who the Action Research and Action Learning ‘Elders’ were in their organisations and fields. This has led to a range of strategies and discussions that also revisit non-Aboriginal Elder wisdom.

Putting new knowledge and learning into practice

We then asked participants how they would put their new learning into practice in their work place or community. Many spoke of changing or reminding themselves to work in ways that enabled people to have greater ownership of programs and research. *Community consultation, being willing to listen and really hear, working respectfully and using critical reflection* were ways that people would do this. Many spoke of *a renewed interest in collaborative practice and participative approaches* and ways that they could see this working in their work place or community. One spoke of identifying and drawing on Elder wisdom in the field of Action Research and Action Learning.

In the university/education sector there were specific strategies including; *continuing to use PAR in research and share knowledges gained with students across the faculty; Creating such an environment of listening, hearing and sharing experiences, actually in teaching in learning, and giving a seminar within my school to highlight the statement and the relevance of action learning and action research (in the context of a strong push by the RCT lobby (Team SA Evaluation 2007).*

The need for of Aboriginal and non-Aboriginal collaborations

Others focused on ways of improving the recognition of Aboriginal and non-Aboriginal collaborations. One group felt that an approach should be made to the government about ways of working with Aboriginal people and communities, highlighting all the successful programs and projects that

Aboriginal people are already doing. It was seen as important to celebrate the success of Aboriginal programs.

One group specifically focused on how action researchers and the conference could support Aboriginal people and communities in ongoing ways. They said;

Research feedback needs to come back to the people in oral or written form, to inform us where we go from here – if we are going anywhere or not. Researchers need to help and support us with the recommendations from these conferences – stand with us and work with us to implement recommendations. Don't leave us standing alone to do the work in our communities. We need long term sustainability. NO SHORT TERM quick fixes!

Many groups recommended that ALARA maintain Aboriginal input into future conferences and publications, with some suggesting that;

ALARA become a central contact point for ongoing communication and discussion and that Aboriginal ownership of stories and ideas should be acknowledged in literature and in writing of health workers and educators.

A special interest group has since been developed.

Concerns

Some of the concerns expressed included the need for *a space to breathe* and *more informal discussion time* and *increased flexibility*. Some said it was not clear at the beginning of the conference what a theme or unifying characteristic was. Others would have liked more theoretical and methodological discussions, but *not at the expense of restricting the scope and range of presenters*. One person commented that the *Indigenous stories were bruising to some extent because they are stories of white oppression*. Another expressed *worrying that action will not be taken after meetings like this*, and that *it is not easy to convince people and move forward despite ideas and drives* (Team SA Evaluation 2007). For some the deep level of sharing, connection and knowing was very challenging. One non-Aboriginal researcher said that he had not had opportunities to work or exchange knowledge with Aboriginal people before

and he found the Aboriginal content and matter of fact discussions about colonisation and colonising effects very profound and disturbing. He said he was '*going home to re-think everything*' (Team SA Evaluation 2007).

Unexpected outcomes

As well as information sharing about health, environment and education, other forms of cultural sharing took place, enabling healing, connections and a deeper sense of well-being. Some of these encounters were shared with Team SA for inclusion in the evaluation in de-identified form. For example one young Aboriginal man met an Elder man at the end of a session and as they sat talking together the Elder man reconnected the young man with some of his family who he had lost contact with. An Aboriginal Elder woman dreamt a vision to be shared with another Aboriginal woman from the other side of Australia. They had never met before, but did so at the conference, and the moment and message were deeply profound.

A Maori Elder woman from Aotearoa / New Zealand attended the conference and many people valued the way she quietly shared her wisdom and knowledge. Her comments generally enhanced our understanding of colonising similarities and differences between our two countries. Aboriginal Elder women sat with her in long conversations discussing issues and strategies. She also spent much time with younger participants, encouraging them to continue with their work and studies. She herself had just finished her PhD and she was very encouraging of others wishing to do further study. Many people connected with her deeply and relationships are continuing with a planned revisit.

Receiving cultural approval to use Ganma

Importantly for this research, thesis and myself, I was able to meet two Yolngu women Dorothy Yunggirringa and Joanne Garnggulkpuy and seek their approval to use Ganma as a guiding concept in this research. I had been concerned about using the concept without seeking expressed permission from Yolngu people. The two Yolngu health professionals were assisted to attend the conference through sponsorship, and their presentation on Yolngu PAR processes was extremely popular. Throughout the three days the women

watched and listened and at the end of the conference they told a Team SA member from the Aboriginal Health Council of South Australia (that they had a long term relationship with), to tell me that I could use Ganma to guide my research. This ‘cultural approval to use Ganma was very important to me, my supervisors, mentors and fellow Team SA members. We had *walked our talk*, and enacted Ganma in a way approved by Yolngu women themselves.

A follow up workshop a year later

In 2008, ALARA, Team SA and Tauondi College renewed our partnership to plan a one day collaborative workshop, funded by the budget surplus as agreed. A one-day follow up workshop titled *Moving Forward Together: the Journey Continues* was planned by Team SA members. Following recommendations from past participants, we planned a more interactive workshop, with emphasis on using research in practice, including discussion about how to begin and utilise PAR in the workplace. The workshop was timed to coincide with a visit by Ernie Stringer and Canadian researcher Josée Lavoie, enabling wider knowledge sharing to occur.

Thirty people attended, including eight community services students from Tauondi College. Presentations and discussions were provided by very experienced researchers and those who had just completed their research studies with the Aboriginal Health Council of SA. Approximately one third of the participants were Aboriginal and two thirds non-Aboriginal. People came from a wide range of disciplines and sectors (family services, mental health, law, childcare, primary health care, education, academia, and environment). All agreed that the workshop was very useful and plans are in place for follow up workshops every six months in conjunction with Tauondi community services students.

The significance of our collaborative research

Co-researcher reflections – Team SA

Following the conference I invited Team SA members to reflect on their experiences of being part of Team SA, working collaboratively to plan,

implement and evaluate the conference. I devised an electronic questionnaire that people emailed back to me, and we had open discussions about our experiences over dinner. Kim and I planned to present our (collective) experiences of planning, implementing, evaluating and experiencing the conference at an international Critical and Feminist Nursing Conference in Canada, and we invited comments to help us write our paper.

Generally Team SA members all indicated that the conference met and exceeded their expectations and vision. They all spoke of unexpected outcomes that they had heard about; the reconnection of Aboriginal people to family, the 'light bulb' moment for a non-Aboriginal person when they suddenly understood the depth of colonisation in our country; the re-invigoration of tired workers who were struggling to meet complex needs in their workplaces; the quiet pride of an Aboriginal community member whose knowledge had been respectfully heard.

At a joint meeting Team SA members reflected that the collaborative planning process offered capacity building opportunities to *increase knowledge and skills in a variety of areas that they wouldn't usually undertake*. It was a *larger than usual planning group* but one that was also *well organised, shared the well-being of the conference and its intentions as an equally held responsibility as well as passionately regarded .priority*. Having two people (Kim and I) coordinating the team and process was important for *communication and keeping the process on track*. However, Team SA members also valued the *shared leadership with different people taking the lead at appropriate times*.

When asked to comment on whether anything made this conference and planning process different to other processes they have been involved in, one academic reflected that;

Other conferences are very narrowly defined, usually in one particular specialist discipline. I have never participated in an integrated conference, bringing together disparate disciplines, for bridging harmony. The joint papers and partnerships between University and Aboriginal speakers are quite unique. I like the idea of helping out people that have never given a paper before, or people who would normally be too shy to put themselves forward (Team SA E1).

When asked what specifically worked for them, another replied;

I enjoyed working with people who are more embracing and nicer to each other than people in science. Sociologists and health workers have much better people skills and are not so viciously competitive. Everyone has been involved; everyone is included in the emails. It has been a distinct pleasure to work with other people on the committee. I have always done action research and felt very alone. Now I can talk to others doing action research in the same way (Team SA E1).

These comments highlight that the collaborative planning process enabled Team SA members to connect with each other and support each other, sharing knowledge democratically and openly, rather than in competition. We all owned the process, shared the vision and could take on another aspect if needed. Together we developed a diagram to represent many of the different aspects that the conference enabled us to bring together and address. These were the aspects that underpinned our planning process.

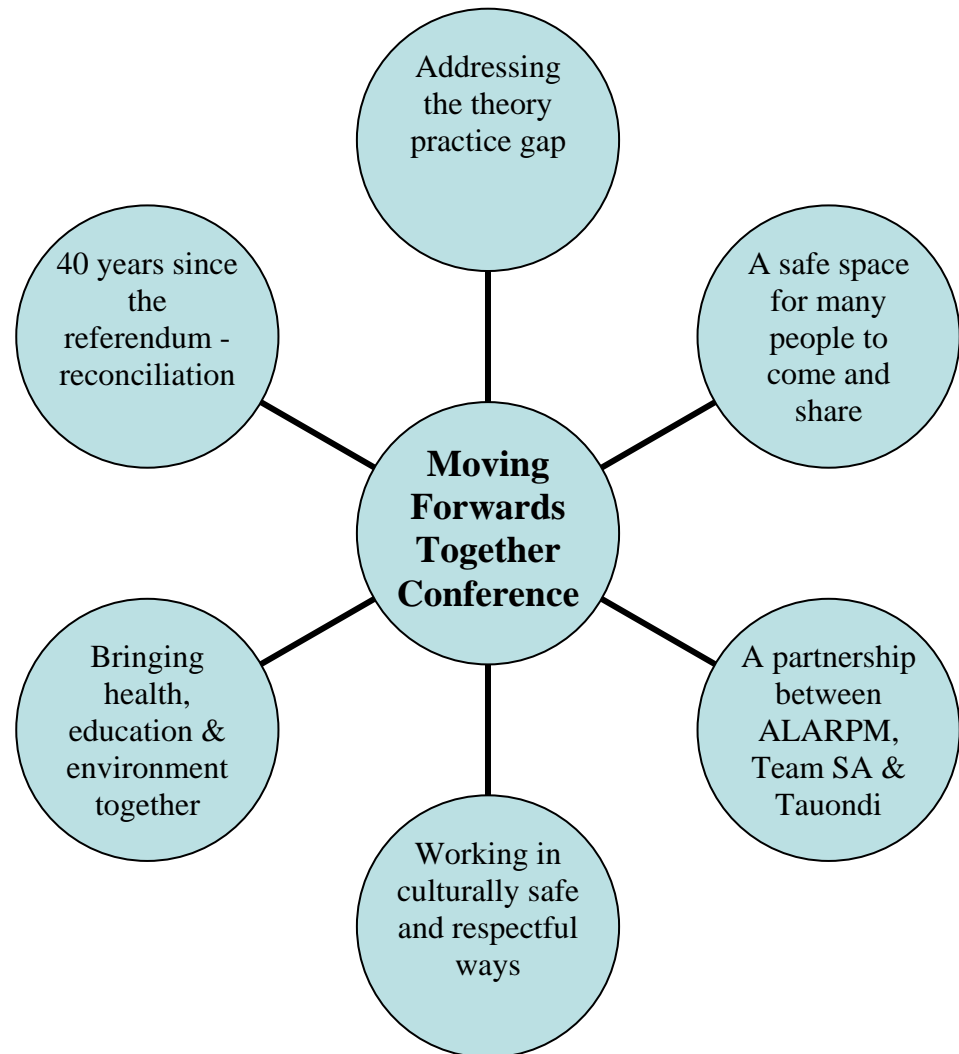


Figure 10.1 Aspects of the Moving Forward Together Conference

In retrospect, Team SA members agreed that organising such a collaborative conference was both hugely enabling, and exhausting. Team members attended planning meetings and assisted between their work, family and personal commitments. Both ALARA and Tauondi were undergoing periods of restructure and management in the six months leading up to the conference, meaning that negotiations were made, and remade in changing environments. I became the main link person between Team SA, Tauondi College and ALARA by the virtue of having the most available time through my PhD.

This conference enabled people from different professions and backgrounds to interact in a space that valued Aboriginal peoples' experiences and ways of working. By its very nature, it created new dynamics, some more comfortable than others. Occasionally tensions arose. For example, in one workshop

community based practitioners chose to focus their presentation on their experiences and stories of working in collaboration with community members, rather than discussing in depth the methodological theories that underpinned their practice. A researcher in the audience, who had spent many years contemplating deeply the intricacies, similarities and differences of action research, action learning and community development, asked the practitioners to differentiate between community development and action research. For most of the practitioners, these concepts were intertwined in a very practical and pragmatic sense. For the researcher, the concepts were vastly different and melding the concepts together was offensive. This interaction highlighted very different viewpoints about academic theoretical concepts and practical application.

My reflections as a nurse researcher

This Collaboration Area was a huge learning curve for me. In many ways I took my belief in what was possible and ran with it, with like minded people. The PAR process of Look and Listen, Think and Discuss and Take Action provided a safe and effective framework, assisting us to follow through all the steps, working in collaboration and finding creative ways of doing things together. Developing a partnership between Team SA, ALARA and Tauondi College was at times challenging, particularly when the people involved, the agreements, arrangements and priorities changed. I learned the skill of gently yet firmly holding the collaborative process together, allowing Ganma knowledge sharing foam to emerge while ensuring tangible and pragmatic outcomes and timelines were met.

Working alongside Kim O Donnell I learned how to create and hold a space that is truly collaborative and promotes consensus while meeting set deadlines and expectations (such as meeting budgets). I learned the benefits of holding a group of people together, but not too tightly, letting the information come in, recording it, sharing it, and letting it continue to flow. This is the kind of space that enables creative and spiritual things to occur. Holding control too tightly keeps creative possibilities and unexpected benefits away.

Themes and discussion

In this section I discuss the findings from this Collaboration Area under the themes of knowledge sharing, working together and addressing issues. Although the themes and findings overlap this format provides a basic structure for this discussion.

Knowledge sharing

This Collaboration Area demonstrated what is possible when respectful knowledge sharing spaces are created. By positioning Aboriginal preferred ways of knowing and doing as a central rather than a marginal theme, the conference was able to become another step forward in decolonisation (Smith 2003) and postcolonial transformation (Ashcroft 2001b).

Working together

Combining aboriginal knowledge and action research

The process of planning, implementing and evaluating the conference, with Team SA, ALARA and Tauondi College working collaboratively together, enabled Aboriginal knowledge and action research and action learning to synthesize. Prior to the conference, ALARA had very few Aboriginal members and no specific focus on Aboriginal concerns. Following the conference there were at least fifty Aboriginal members and ALARA has created a special interest group and a section of the web site that focuses specifically on issues and processes for Aboriginal people and communities. Links are continuing between ALARA, Tauondi College and Team SA, and ongoing programs are have been organised. This has led to strengthened collaboration across sectors and cultures, and ongoing discussions about how action research and action learning can be combined with Aboriginal knowledge to create culturally safe interactions. Kim O Donnell has introduced the NHMRC *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research* document (2003) as a guide for culturally safe and respectful research. At the follow up workshop in 2008 we focused on how action research and action learning has been successfully used in Aboriginal health, education and environmental programs to enhance pragmatic collaboration.

Testing our PAR in a wider domain

At a more personal level, this conference enabled co-researchers and I to road test our collaborative PAR in a wider, inter disciplinary, inter-organisational setting. We found that our process of look and listen, think and discuss worked just as well for organising a national conference as it did to work with a small group of community women, an emerging health service, or across health and education sectors. The Cooperative Research Centre for Aboriginal Health (CRCAH) (Brands 2005) has identified the need for brokering between governments, academics and community controlled health services, and effective ways of bridging evidence, policy and implementation strategies. Our collaborative approach enabled us to address many of these issues. By bringing together a diverse range of people to discuss health, research, education and environment in a myriad of ways, research knowledge and experiences were effectively transferred.

Addressing issues***Recognition of Indigenous postcolonial knowledge***

One significant issues addressed by this collaboration project relates to the recognition and support of Indigenous knowledge. As suggested by Browne et al (2005), Battiste (2000) and Smith (2003) it is important for Indigenous people to add their voice to postcolonial discourses, developing postcolonial knowledge based on Indigenous ways of knowing, worldviews, research processes and experiences. Aboriginal knowledge, like other Indigenous knowledge, has developed to address the complexities, discriminations and assumptions associated with colonialism, such as those discussed in the colonisation chapter. It can be used with Western postcolonial theory in democratic and respectful knowledge sharing ways, but should not be consumed by Western postcolonial knowledge, or *taken over* by non-Aboriginal people. Our conference enabled both Aboriginal and Western postcolonial knowledge to be recognised in its own right, and then shared intentionally through respectful two-way Ganma knowledge sharing. For example, the panel discussions at the opening of the conference enabled this concept to be experienced by all participants as they watched and heard the

discussions unfold. Having two Yolngu women present to explain the concept of Ganma, its origins and how it can be used, reinforced everyone's recognition of Aboriginal postcolonial knowledge.

Summing up

This Collaboration Area Four enabled us to present and test our collaborative PAR model in a wider context, across disciplines and sectors, while maintaining a decolonising intent of privileging and embedding research related activities in Aboriginal preferred ways of knowing and doing. Together a team of interested co-researchers (Aboriginal and non-Aboriginal) and I planned, implemented and evaluated a national action research, action learning conference, underpinned by concepts of Ganma two-way knowledge sharing, Dadirri respectful listening, cultural safety and PAR collaboration as both a process and an outcome. Co-researchers and stakeholders generally found the conference a positive, life enhancing, and for some, a life changing experience. A few found it very challenging, or that it did not suit their needs, indicating that this approach does not suit every situation or personal need. Overall, this activity enabled us to *level the playing field*, activate de-colonisation strategies and support the sharing of knowledge in a diverse range of oral, audio, visual, kinaesthetic and experiential ways. Co-researchers reflected that they enjoyed working in a collaborative and supportive team, rather than competitively, and that the outcome surpassed our expectations.

CHAPTER 11 FINDINGS & DISCUSSION

This final chapter brings together and discusses the research findings in relation to health care policies and practices in South Australia. I begin by describing specific events that occurred at Gilles Plains during this research, in particular the changes that impacted on Aboriginal women's access to responsive health care, and health professionals' ability to provide quality care. I discuss these events in the context of state and national policies, bringing attention to gaps that exist between policy intentions and practice realities. I then describe the collaborative participatory action research that we co-developed and implemented enabling co-researchers and myself to explore, prioritise and then address, emerging issues. Using the three central themes of knowledge sharing, working together and addressing issues I present the findings and make specific recommendations. I then discuss the implications that this research has for Aboriginal community women, health professionals, managers, researchers and policy makers. Finally I outline the strengths and challenges of this research and opportunities for further research.

This participatory action research project has developed specifically in response to practice dilemmas that I, and Aboriginal and non-Aboriginal primary health care colleagues have encountered in trying to provide quality health care for and with Aboriginal women in urban settings. The need for quality and comprehensive primary health care to adequately address the complex needs of Aboriginal women and their families in Australia has been clearly identified in multiple documents, and again in this research. The 2007/8 'Close the Gap Campaign' (Oxfam Australia 2007) and the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 (2004) specifically promote holistic, coordinated and collaborative approaches to counter the seventeen year gap in life expectancy between Aboriginal and non-Aboriginal people, and the ongoing effects of colonisation, racism and exclusion and associated lower levels of social determinants of health. The National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 (2004) suggests nine principles of effective and responsive health care. These principles include;

a holistic approach, cultural respect, health sector responsibility, community control of comprehensive primary health care services, working together, localised decision making, promoting good health , building the capacity of health services and communities, and accountability (p 4).

These nine principles are very important building blocks upon which meaningful and responsive primary health care can be built. If they were effectively implemented, they would go a long way toward 'Closing the Gap' in health inequalities. Hopefully an all of government and health service agreement, backed by solid bipartisan commitment will, in the future, lead to significant positive action. This is what is needed for significant change to occur. In the meantime, health professionals face the task of trying to provide health care as best they can within an under resourced and constantly changing primary health care system.

The impact of non-collaborative changes in primary health care

Over the last forty years, a confusing array of local, state and federal policies, programs and strategies have been developed and trialed in Aboriginal and mainstream services within South Australia (and Australia). Some of these have been more successful than others from the perspective of community members and health professionals (Community consultations 2005). Health system changes signaling a change from comprehensive primary health care to selective primary care and back again have added to the confusion. Significantly different philosophies underpin these two primary health care approaches (World Health Organisation 1986). Comprehensive primary health care embraces concepts of holistic care, responsive to local people's health needs and social determinants of health. Collaboration and engaged participation are encouraged and health care is recognised as being inherently political. Both client and professional knowledge is equally valued and two-way knowledge sharing is encouraged. In comparison selective primary care has a more biomedical focus, concentrating on the elimination of specific illnesses or diseases. It is apolitical and values professional knowledge over community or client knowledge, with client compliance rather than collaboration being a dominant feature that is encouraged (Baum 2008). These

two very different primary health care approaches lead to quite different experiences and expectations of both clients and professionals. When they are used interchangeably, or when suddenly there is suddenly a shift from a strong emphasis on collaboration to compliance, health professionals and clients alike find it very confusing. These differences are not always well understood or explained.

To illustrate the impact of these differences more clearly, I now revisit the observations, discussions and analysis of Aboriginal community women, health professionals and myself as we experienced, and then reflected on the development of primary health care at Gilles Plains. I do this with the intention of highlighting the significant impact of changing health policies and practices rather than to cast judgment or blame. This account clearly shows how specific expectations have been built and not met, leading to Aboriginal people becoming frustrated and disconnected from health services. Health professionals and local managers were often powerless to prevent health systems changes from occurring, but were blamed by Aboriginal community members because these staff members were the visible face of the health system.

In 1999, comprehensive primary health care programs were actively encouraged at the Gilles Plains Community Campus. A very popular Aboriginal Young Mothers' Group based on holistic and comprehensive primary health care principles was provided, supported by Aboriginal and non-Aboriginal health professionals from the Adelaide Central Community Health Services, Aboriginal health team, and Child and Youth Health Service. This program was responsive to local women's needs and included health information and health checks as well as financial, transport, housing and emotional health support. Twenty five to thirty Aboriginal women attended regularly each week (Abdullah 2002).

Also in 1999 a fourteen person reference group comprised of local Aboriginal Elders and community people, community health managers and staff members met to discuss an increasing focus on Aboriginal health care at Gilles Plains. Plans were made for a Gilles Plains Aboriginal Neighbourhood House to be developed. This service was envisioned to be a welcoming and culturally safe

place for Aboriginal community people to meet in the North East suburbs, and access social and emotional well being and health programs (Community consultations 2005; Gilles Plains Community Health Centre 2004). The Department of Health committed to remodelling an old school building and community members and health professionals began waiting and planning in anticipation.

In 2002 the Aboriginal Young Mothers' Group was discontinued due to changing policies in Child and Youth Health (moving from group programs to universal home visiting) and the passing of Aboriginal health care responsibility to the Aboriginal Neighbourhood House. Delays in the development of the Aboriginal Neighbourhood House meant that local Aboriginal people fell into a gap in service provision. The Aboriginal Reference Group was dismantled due to complex issues and the loss of Elders. Community health staff invited local Aboriginal women to attend other established groups at the campus during these changes (Stark & Coulls 2007).

Meanwhile, significant changes were occurring in the state health department. The incoming Labour Government instigated a Generational Health Review with a stated policy commitment to comprehensive primary health care (Government of South Australia 2003c). The health system was restructured into three main urban regions and managers were moved into new positions. This was a time of great unrest within the health system. The Gilles Plains Community Campus became part of the Central Northern Adelaide Health Service (CNAHS). Curiously, although the policies declared a commitment to comprehensive primary health care as described in the Alma Ata Declaration (World Health Organisation 1978), community health services found that they were being asked by higher level managers to provide selective primary care with specifically focused health programs (Community consultations 2005). This situation highlights the complexity of influences and interplay between federal selective primary care funding and a state focus on comprehensive primary health care.

Alongside these changes, a partnership between Nunkuwarrin Yunti (community controlled health service) and the South Australian Department of Health was focused on future utilisation of the national Aboriginal Primary

Health Care Access Program (APHCAP) funding announced in the 1999-2000 Commonwealth Budget (Nunkuwarrin Yunti 2008). Plans were made through this partnership to improve access to jointly provided Aboriginal primary health care services at Gilles Plains. The result of all of these changes was that when the Aboriginal Neighbourhood House finally opened at Gilles Plains in 2005, selective primary care rather than comprehensive primary health care programs were provided for Aboriginal people coming from the central northern region of Adelaide. In line with selective primary healthcare philosophy, the new managers expected community compliance and graceful acceptance of these changes. However, local community backlash occurred.

Health professionals working in the newly developing Gilles Plains Aboriginal health services were placed in a difficult position. Staff members from both Nunkuwarrin Yunti (federally funded) and Central Northern Adelaide Health Service (state funded) were encouraged to work together to provide primary health care programs that focused on child and maternal health and chronic conditions care and prevention. Clients were brought to the service from across the region. In the first year there were five different managers, each with their own interpretation of primary health care, and multiple Aboriginal health workers and nurses came and went on short employment contracts or site rotation. Staff members addressed the avalanche of complex health and well being needs as best they could. Meanwhile local Aboriginal people continued to seek the envisioned social and emotional well being programs and were frustrated when these were not forthcoming.

It was during this time that three health professionals at the Aboriginal Outreach Health Service based at Gilles Plains Community Campus and I began to work together on collaborative participatory action research. We sought creative ways to meet some of the local Aboriginal women's health and well being needs with strategies that could complement rather than complicate the services and programs already in place. We planned short and long term projects such as Women's Health Days, resource mapping and networking with other services. Over time, more holistic and well-being programs were developed, partially due to this research, and partially due to an increasing emphasis on social and emotional well being.

Toward the end of 2007 and into 2008, the Aboriginal Outreach Health Service was providing a wide range of services that were generally well attended. The same manager had been in place for over a year and both selective and comprehensive primary health care services were meeting a range of client needs. Collaborative relationships with mainstream community health, the local Division of General Practice and the Women's and Children's Hospital were being strengthened, and women's programs such as midwifery shared care were being developed. While it was not all smooth sailing (many staff members sought employment elsewhere or went on stress leave), the health service began to make significant differences in Aboriginal women's and men's people's lives. Many adults got their diabetes under control for the first time through ongoing group support, exercise and weight loss programs and/or new opportunities to heal from past and present traumatic experiences. Referral to other services enabled them to get their wider health needs met. Local Aboriginal community people and visitors from other areas began building trusting relationships with staff from the health service. The Aboriginal Outreach Health Service had moved closer to the original vision of a responsive Aboriginal community service that provided both comprehensive primary health cares. It more closely resembled the nine principles of the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 (2004). There was a stronger commitment to holistic health, responding to community needs, working together, promoting good health and building the capacity of the health service and community members. From the perspective of the local Aboriginal community this was a very positive outcome.

However, in late 2008, the service underwent massive changes that had significant impact on this careful collaboration and health service capacity. At the time of writing (mid December 2008), higher management decisions in the Central Northern Adelaide Health Service (CNAHS) are signalling changes to the way that Aboriginal health services are to be provided at Gilles Plains, and perhaps other sites across the region. Aboriginal services are to be downsized with only one site manager, one receptionist and two Aboriginal Health Workers remaining. Clinical services are to be provided by a visiting

(CNAHS) doctor/nurse/receptionist team. Six staff members at Gilles Plains who are on contracts will become unemployed as of Christmas Eve, and the manager and one receptionist are being moved off site. Staff from Nunkuwarrin Yunti who currently provide clinical services and women's centred care do not know whether they will still be positioned at Gilles Plains next year, or moved to another site. Community members have not yet been officially told of the changes, but they know *something is up* and they have certainly not been consulted or informed (Community consultations 2008). The partnership between Nunkuwarrin Yunti (Adelaide's Community Controlled Aboriginal Health Service) and CNAHS is in serious jeopardy. Collaborative programs involving other services have been disrupted or discontinued.

This is a very disturbing end to the growing trust and collaboration that involved had evolved by involving Aboriginal community women, health professionals, onsite managers and visiting service providers. Once again, services that local Aboriginal women and their families contributed to, and value, are being discontinued. Health professionals who have committed to improving Aboriginal health at Gilles Plains are being forced to walk away, knowing that they take Aboriginal clients' expectations with them. The gap is widening.

This series of events poses very serious questions about the real intentions and impacts of our health system, and whose needs the health system is really focused on. Unfortunately it reinforces the belief spoken between Aboriginal community members and Aboriginal health workers that *if a program is working, don't tell anyone or it will be discontinued* (Community consultations 2005). The personal cost for all involved is incredibly high and I question that this is an acceptable 'side effect' of systems change. I also question how this top down approach of rapid and drastic non-collaborative change could possibly counter the ongoing devastating effects of colonisation, discrimination and exclusion of Aboriginal people. One cannot help but conclude that despite its purported goal of Closing the Gap, the health system is in fact continuing the colonisation of Aboriginal women clients and health professionals through such arrogant, unilateral, and one sided decision making.

In this era of Close the Gap (Oxfam Australia 2008) we know that to even start to redress the appalling health status of Aboriginal Australians we have to move beyond unsustainable approaches that have been revealed in this account, and urgently and truly listen to and work with the Aboriginal community to ensure we can move forward together and significantly improve the health and well being of Aboriginal women and their families. Aboriginal health inequalities are too serious for us to keep 're-inventing the wheel', reinstating programs that have not worked in the past, and ignoring or dismantling projects and programs that are working. Precious time and significant resources are wasted in duplication and dislocation, and lost opportunities for building trustworthy working relationships that may never be recovered.

Similar concerns to those raised by this research regarding top down decision making and inadequate consultation with local community members and health professionals who have established working relationships were also raised in the review of the Northern Territory Emergency response. The Review Board (2008, pp. 9-10) advised that;

The most essential element in moving forward is for government to re-engage with Aboriginal people... based on genuine consultation, engagement and partnership.

I argue that these same mistakes are yet again being repeated in urban Adelaide health services today and that it is way past time for decision makers and higher level managers of health services to find culturally respectful and proper ways to work with Aboriginal communities in decolonising collaborative approaches. A proactive step forward now is to commit to programs and employment for at least five and preferably ten years to enable programs to be fully developed and implemented. Appropriate checks and balances would need to be put in place to ensure that programs were evaluated by the community as well as government to ensure that they were effective. PAR processes would be ideal for this purpose as they involve elements of flexibility, evaluation and continual improvement.

There is clearly a need for solid commitment to improving Aboriginal health and well being with agreed goals, targets and strategies. The Close the Gap

Campaign(Oxfam Australia 2008) and the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 (National Aboriginal Torres Strait Islander Health Council 2004) provide directions for such positive changes through the nine principles discussed previously. The difficulty lies in committing to and implementing them at all levels of government and health service delivery. While I recognise the need for this to occur, the ability to implement such changes goes beyond the ability of this research, the co-researchers and myself as a community health nurse. While I can advocate and lobby, I cannot instigate or guarantee such level of change. However, this research is still important as it offers a clear focus on what changes are possible through positive and respectful client/health professional interactions, and how collaboration can enable progress for Aboriginal community members and health workers even when the health system they are trying to work with retracts from its rhetoric of effective collaboration as a basis for improving Aboriginal health outcomes.

Collaboration as a way forward

This research sought to Close the Gap through finding pragmatic and responsive ways that Aboriginal and non-Aboriginal health professionals and Aboriginal community women could work together to meet complex Aboriginal women's health and well being needs, *regardless* and *regardful* of what the health system was doing at the time. As discussed, neither health professionals nor community women assumed that the health system would recognise or support the importance of collaboration, or comprehensive health care. While policy documents have stated the government's commitment to comprehensive primary health care and collaboration, service models and practice reality proves otherwise. In order to move forward together, community women and health professionals needed to take proactive steps to initiate collaboration from the ground up, in full recognition that the health system may or may not support their commitment to such collaboration. They needed to be both optimistic and pragmatic about the possibilities and limitations of any collaboration, recognising that immediate needs may be met, but longer term needs may not. A clear understanding of these realities is needed to prevent unrealistic expectations from developing.

Collaboration involves both a process and an outcome. This research found that the process of being involved in collaboration was usually enabling and positive. Aboriginal community women co-researchers reflected that being involved in collaboration, being heard, acknowledged and included, countered daily negative experiences of being excluded, unheard, ignored and overlooked. They found the process of collaboration very healing, even when the outcomes were short lived. Their experience of being included and recognised as a valuable partner was a step forward. Similarly health professionals found the process of being listened to and involved in co-planning programs very healing. Rather than having to implement top down selective primary care programs that may or may not work, they were able to use their professional expertise, commitment to consultation and knowledge to co-create effective and responsive comprehensive primary health care programs.

Co-researchers and I agreed that participatory action research (PAR) would be an effective methodology for our collaboration. We identified a need to adapt Stringer's (2007) model of *Look Think and Act* to become repeated cycles of *Look and Listen, Think and Discuss* and *Take Action*. These changes reflected an emphasis on the importance of listening respectfully to each other, being heard and discussing issues with each other before taking action. We trialed this model of collaborative practice in a range of health care and education settings and found it very useful and responsive to meeting Aboriginal women's comprehensive primary health care needs. Four specific areas of collaboration were explored and these included; working with Aboriginal community women who felt marginalised from the health system as a result of continual health system changes and unmet expectations; health professionals attempting to meet complex client needs with minimal resources and support; collaboration between the health service and local high school to better meet the needs of young Aboriginal women; and an inter-sectorial and interdisciplinary national action research and action learning conference embedded in Aboriginal preferred ways of knowing and doing. In each of these Collaboration Areas, three central themes of collaboration emerged and became the central theses of this research. They are; knowledge sharing,

working together and addressing issues. These themes relate to the three phases of our PAR model as can be seen below in Figure 11.1.

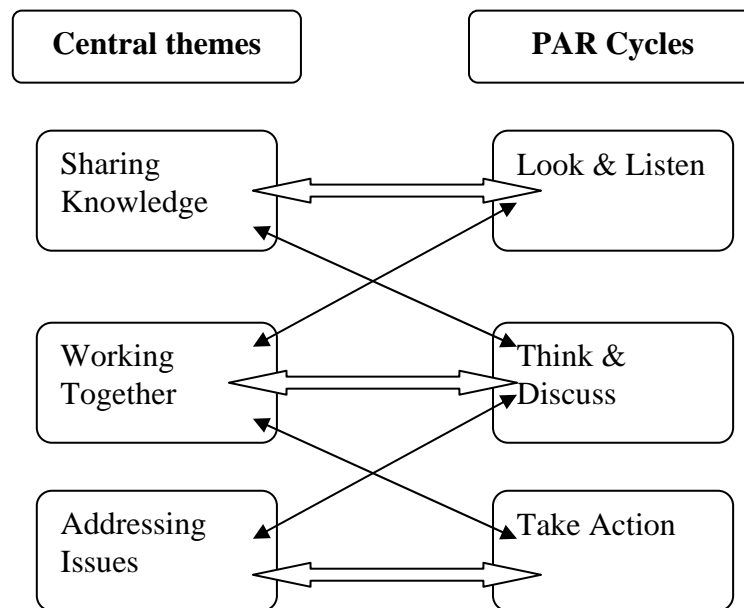


Figure 11.1 The correlation between the PAR cycles and central themes

These three central themes embody aspects that co-researchers and I believe are most crucial for effective collaboration. They are simple to understand and discuss, and yet represent deep concepts related to colonisation, inclusion and exclusion and healing explored through our PAR. These three themes are now used to discuss the findings and recommendations.

Knowledge sharing

This research has identified the crucial role that effective and respectful communication plays in collaboration and the improvement of Aboriginal women's health and well being. Many Aboriginal women participants spoke of the importance of being able to connect with health professionals and build trustworthy relationships with them, in order to feel culturally and personally safe when accessing health care. In practice however, Aboriginal community women, Aboriginal and non-Aboriginal health professionals, managers, policy makers and allied health professionals may all hold quite different understandings. Individual perceptions, experiences and beliefs about health

and health care, Australian society, past and present colonisation practices, discrimination and inclusion or exclusion can impede effective communication. As well as this there are different perceptions about the correlation between knowledge and power (Habermas 1972).

In this research, concepts of democratic two-way knowledge sharing were found effective in bridging gaps in knowledge and power across positions and cultures. Aboriginal models that took into account the impact that past and present colonisation, discrimination and exclusion have on effective communication and collaboration, were found particularly useful. The two models used in this research, Ganma (Gullingpuy 2007) and Dadirri (Atkinson 2002), highlighted the importance of respectfully listening to each other and bringing together different perspectives to create new understandings. These models recognised the importance of self awareness and openness to new ideas for effective cross cultural communication to occur. They helped to pave the way for culturally safe health encounters to begin (Ramsden 2002). Aboriginal community women co-researchers indicated that collaborative and respectful forms of communication were both necessary and healing and led to improved experiences of health care and programs. Health professionals found that these models of knowledge sharing and cultural safety were more easily incorporated within comprehensive, rather than selective primary health care programs. Comprehensive and holistic programs recognised the need for diverse knowledges to be shared for collaborative understanding and action to occur. Selective primary health care models supported this less easily due to the privileging of external biomedical knowledge over health professional and client knowledge.

Health professionals also identified the need for improved knowledge sharing within health organisations. They indicated that very little knowledge sharing occurred vertically in their health organisation during the time of this research. Top down selective primary care policies expected health professional as well as client compliance. They did not allow professional knowledge to be meaningfully included in decision making about health care programs. Gaps in understanding developed between health professionals who worked directly with local women, and the external managers and policy makers who set the

health care agenda. Health professionals' recognition of the hugely complex nature of clients' health and well being was overlooked, and simplistic selective health care programs and directives were expected to be implemented. When inadequate selective primary care programs did not run smoothly, health professionals felt blamed for *health program failures* by higher level managers. Inadequate and at times unsafe communication pathways prevented health professionals from safely feeding information and critique back up the line.

This situation calls into question what is accepted as evidence based practice in primary health care and research. This research identified that culturally safe and client centered care required client and health professional knowledge to be recognised as significant *evidence*, alongside technical and biological knowledge. Unmodified and unquestioned selective primary care can not adequately address the deep rooted social, economic and historical factors that underlay the health disparities that many Aboriginal people continue to experience. Health professional and client knowledge needs to be recognised and included in bottom up policies and decision making. Experientially based intuitive understanding should be considered as evidence, and evolving research agenda should constantly question who defines best evidence, and who judges it (see for example MCHenna 2000 and Rycroft-Malone, Seers, Titchen, Harvey, Kitson & McCormack 2004) For this to occur, two-way knowledge sharing between health professionals, managers, policy makers and scientists would need to occur. This would require changes in perceptions about power and knowledge and a swing back toward comprehensive primary health care across all levels of government and the health care system. Concepts of Ganma two-way knowledge sharing and Dadirri deep listening were more successful in bridging understandings between different sectors and agencies, such as the health service, the youth sector and local high school. A shared understanding of the holistic and comprehensive health needs of young Aboriginal women and the impacts of lower social determinants of health emerged. From this specific strategies and programs were successfully developed.

This research also identified the need for Aboriginal women's knowledge to be heard and acknowledged in health care and in Australian society generally. While policy documents highlighted the importance of Aboriginal community consultation and inclusion in decision making, this was not the experience of the Aboriginal community and health professional women involved in this research. We undertook specific strategies to counter this trend, such as co-writing and co-presenting our findings at conferences and workshops involving policy makers and primary health care managers and professionals. This process took time and care to nurture and develop, but the resulting presentations were a vast improvement on what I would have done alone. In order to gain from collaborative processes, care and time does need to be taken.

However, not everyone is interested in, or in the position to share knowledge. Professional and cultural boundaries, egos, previous experiences of violation and abuse of shared knowledge and underlying colonising beliefs can all prevent knowledge sharing from occurring in health care settings. Collaborative models such as PAR and comprehensive primary health care rely on some degree of knowledge sharing. The extent to which people are willing to engage with knowledge sharing will to a large extent determine the level of collaboration can take place. This research has found that even some degree of negotiation and power sharing can lead to positive changes. For example, while some managers were unsure about the collaborative program at Gilles Plains, we were able to provide enough evidence of its benefit for them to support it. If all workers were supported to engage in knowledge sharing, and if the health system was seen to be a safe place in which to do so (horizontally and vertically) then knowledge sharing within and between health and other services would increase as has been evident during times when comprehensive primary health care has been well supported. Ideally knowledge sharing would take place between Aboriginal and non-Aboriginal health professionals, Aboriginal community women, managers, policy makers, funding bodies and other allied services as is shown in Figure 11.2 .

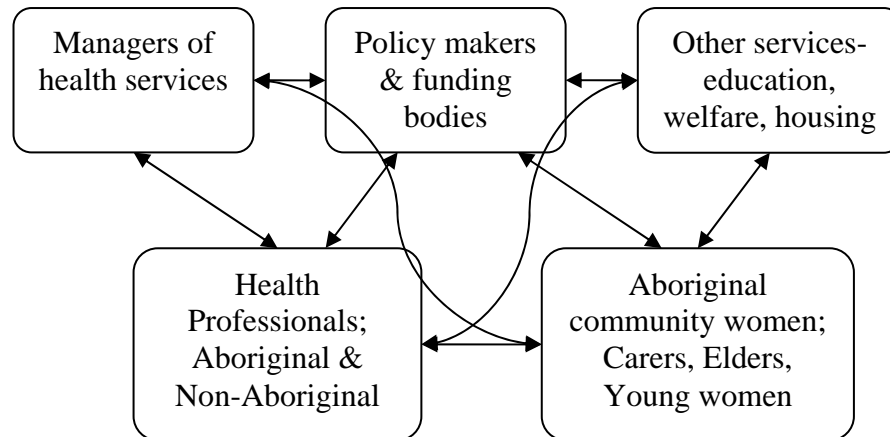


Figure 11.2 Knowledge sharing necessary for effective comprehensive primary health care

These forms of knowledge sharing may happen to greater or lesser extents, but it is important that they do happen for health care to become more responsive and coordinated.

Recommendations for knowledge sharing

Reinstatement of models of practice that support knowledge sharing

There is an immediate need for models of practice such as comprehensive primary health care (CPHC) and collaboration to be supported by all levels of government and health services. Only through improvement in two-way communication between Aboriginal community members and health services will significant and lasting changes be made to the health and well being status of Aboriginal women and their families. Experienced CPHC practitioners should be supported to mentor and educate newer practitioners into the role to ensure that this skills base is not lost.

A review of what constitutes evidence based practice

Client and health professional knowledge needs to be acknowledged as significant aspects of evidence based practice alongside biomedical knowledge, particularly in primary health care settings. Unmodified scientific knowledge cannot adequately address deep rooted social, economic and

historical factors that underlay health disparities experienced by many Aboriginal people.

Increased health professional and community involvement in policy decision making and implementation

Aboriginal community women and health professionals need to be supported to become more involved in policy decisions regarding health care programs and implementation in order to prevent discordant health care. Respectful consultation followed by local collaborative and responsive action needs to be incorporated with national and state policies at an organisational level. This was successfully implemented with non-Aboriginal women in the National Women's Health Program. Similar strategies could be combined with cultural safe approaches to improve Aboriginal women's and health professionals' involvement in policy decisions and implementation.

Working together

The second aspect of improving Aboriginal women's health and well being identified in this research, involved working together collaboratively to address issues that were raised. Once knowledge had been respectfully shared and discussed, responsive action could be undertaken. In this research, we found that past and ongoing negative colonisation, discrimination, racism and exclusion experiences impacted on the way that Aboriginal and non-Aboriginal women and health providers could work together. Many Aboriginal women discussed needing time to get to know health professionals in order to trust them enough to discuss deep and underlying health issues.

The changing emphasis occurring in the health sector from comprehensive to selective primary health care and back again was very confusing for community Aboriginal women and health professionals alike. As discussed earlier, each model of health care supported quite different expectations and experiences of knowledge sharing and collaboration. For example, community women were encouraged to attend comprehensive primary health care programs weekly, but discouraged from attending selective primary care clinics so regularly. When the women's greatest need involved seeking

ongoing support, they attended what ever service was available, whether it was designed for that purpose or not. This led to complaints that they were monopolising services and the clinic was in danger of over servicing.

By working together collaboratively we were able to address some of these issues proactively. First we discussed different forms of primary health care so that everyone could gain a similar understanding and expectation of the available services. Once this was clear, the community women decided to form their own Women's Friendship Group and access parenting services at other sites that could meet their specific needs. Meanwhile, local health professionals used PAR processes to map available and additional resources, create collaborative networks with other services and prioritise short and long term goals that were responsive to local Aboriginal women's needs. The three step PAR process of *Look and Listen*, *Think and Discuss* and *Take Action* enabled resulting collaborative projects to be well thought out, inclusive and effective.

Co-researchers found that by working together they could pool their resources, time and energy and achieve much more collaboratively than they could alone. For example, local Aboriginal community women and health professionals co-developed a series of Aboriginal women's health days to meet both health service and community priorities. Education professionals and young Aboriginal women were also included in the health days and the program expanded to meet their additional needs. By working together health and education professionals were able to positively address issues related to lower social determinants of health in ways that they couldn't alone. Young Aboriginal women were able to access a wider range of resources to support them to be healthy, stay at school, seek further training and gain well paid employment. The Young Aboriginal Women's Get together for example enabled young Aboriginal women to access general health and contraception information, be involved in reconciliation and leadership programs while having opportunities to deepen their friendships, expand their public speaking skills and explore social, emotional and cultural well being.

We found that in order for collaboration to work across organisations and sectors, at least one person in each agency needed to be supported and willing to take a leadership and collaboration role. A clear action plan (derived through

PAR), management support, and additional resources such as catering and transport was also important. Our collaborative and flexible PAR approach was used for small one off events, ongoing programs, and national events like the action research action learning conference. We found that benefits of collaboration and positive outcomes far outweighed the energy taken to begin the collaborative process. Once collaboration began, it a collective energy was generated that spurred us all on.

Recommendations for working together

Promoting reconciliation in health care, school and work places

Many non-Aboriginal people presume that the need for positive reconciliation between Aboriginal and non-Aboriginal people has reduced. Conversely, this research found that reconciliation education, programs and projects are required to counter ongoing experiences of colonisation, racism, discrimination and exclusion. Reconciliation programs and projects need to be incorporated into annual events in health centres, schools and other workplaces.

Collaborative processes such as PAR being incorporated into health care

Many health professionals identify the need to work collaboratively with community members and professionals from different agencies, but are unsure how best to do so. PAR processes such as Stinger's *Look, Think, Act* or our *Look and Listen, Think and Discuss and Take Action* provide an easy to understand process that incorporates the main principles of successful collaboration.

Continuation of Aboriginal Worker research training

In 2008 the Aboriginal Health Council of SA began research training developed by James Cook University. This provides Aboriginal health, childcare and welfare workers with skills in planning, conducting and evaluating research relevant to their workplace. It has been a very successful program but is only funded for one year. This program should be continued.

The need for networking to be supported in health care

An important part of collaboration involves networking. In order to meet complex client needs, health professionals need to be able to network with a

range of other service providers. Skills and activities in networking need to be supported by health services and managers and seen to be core business.

Addressing issues

The third aspect that this research involved identifying wider issues that affect Aboriginal women's health and well being, and finding pragmatic ways to address them. Specific issues related to ongoing colonisation, discrimination and exclusion effects and health care access and experiences were highlighted in this research. Both Aboriginal and non-Aboriginal co-researchers acknowledged that while non-Aboriginal people may experience similar issues to Aboriginal people, very few experience the compounded effect of multiple and intergenerational issues complicated by ongoing colonisation policies and practices . This research found that in order to improve health and health care access, issues related to colonisation and exclusion need to be positively addressed. This would require multi agency, policy and political changes such as those described in the Close the Gap Campaign (Oxfam Australia 2008) and the nine principles of the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 (2004).

In relation to health care provision, Aboriginal community women and health professionals identified the importance of *healing* in health care to positively address these issues. There are many different parts to the concept of healing. Aboriginal community women sought collaborative programs that could counter their experiences of being ignored, unseen, unheard, unrecognised, misunderstood and marginalised. They imagined a supportive health care environment that could help them to address the high levels of stress they were experiencing in their lives. They identified the need for relationships between health services and themselves to be improved and strengthened, or in their words, *to heal*, before they could re-engage with the health system. They indicated that sometimes accessing a health service was a personally and culturally unsafe activity and that in order to (re)engage, old hurts, expectations and experiences needed to be healed.

Health professionals also spoke about the importance of healthy environments and *healing* for themselves. They discussed being caught between community

and health service expectations, and trying to meet local Aboriginal community needs amongst wider priorities and directives. They often took the brunt of community anger, frustration, grief and loss, and suffered vicarious trauma when listening to distressing stories. Health professionals spoke of having very little support for the difficult decisions and care that they provided, particularly around grief, violence, abuse and mandatory reporting. They began taking sick leave to give themselves a chance to heal. In addition, they experienced frustration that their professional and cultural knowledge was not always acknowledged or supported, particularly by higher level managers. They felt blamed, or blamed themselves when things (beyond their control) *went wrong*. These co-researchers indicated that being involved in this research process was healing and enabled them to keep going. The process of being heard, of having their concerns and knowledge acknowledged, and being supported to co-create effective strategies gave them the impetus to continue working. Unfortunately, these kinds of issues make working in Aboriginal health very stressful for health professionals, and many leave. Over the four years that this research took place, only one of the twenty staff members at the Aboriginal health service remained in the same position. This has huge impacts on client care and continuity of care. There is immediate need for issues of work force development and ongoing support to be implemented. While this has been repeatedly mentioned in numerous Aboriginal health documents, it is yet to be implemented.

Using a postcolonial feminist gaze enabled deeper recognition of the complexities that exist within Aboriginal women's health care in suburban Adelaide today. As previously discussed, differing models of health provision (selective and comprehensive primary care), changing policies, priorities and health service structures, and changing staff members and managers result in quite different expectations, practices and abilities to meet client needs. Both Aboriginal and non-Aboriginal co-researchers discussed and challenged a misconception that Aboriginal health services can automatically meet Aboriginal women's needs. This research identified that many other aspects besides the 'Aboriginality' of the health service or health professional impacts on whether Aboriginal women's health care and well-being needs can be met.

Firstly, many Aboriginal women experience complex health care needs that can not be met by any one service alone. Aboriginal Health Services are repeatedly mentioned as the health service of choice in Generation Health Review documents, but there is no way that one service can meet all Aboriginal women's needs. Some Aboriginal women spoke of purposefully seeking services in non-Aboriginal health centres due to close familiarity with Aboriginal health care providers, their need for anonymity, and not wishing to burden Aboriginal health providers with distressing issues.

This research supports the move toward Aboriginal specific health services being better funded and resourced **and** mainstream health care responsibility toward meeting Aboriginal women's health needs increased. The health needs of Aboriginal women and their families are so complex that increased collaboration between both services is necessary. As indicated in Generational Health Review documents and interviews in this research, there is also need for cultural models of practice such as cultural respect and cultural safety to be implemented in both Aboriginal and non-Aboriginal services to counter racist and discriminatory practices. Capacity building approaches to 'train the trainer' models have proven to be effective in enabling experienced people to share their knowledge and prepare newer professionals to provide effective care.

Recommendations for addressing issues

Commit to working collaboratively to 'Close the Gap'.

All levels of government, health services and health professionals, need to commit to working collaboratively with the community and one another if they are to Close the Gap in Aboriginal health inequities in Australia. In part this can be achieved through the encouragement and engagement of closer working partnership and networks within the range of health and related services in rural, remote and urban areas.

Recognise the importance of healing in health care

Many Aboriginal women reported that accessing and working in the health system can be unhealthy personally and culturally unsafe. Increased recognition of personal and cultural needs, skills and abilities, as well as the importance of building trustworthy relationships are urgently needed.

Implement cultural models of practice

Within Australia the ongoing impact of colonisation, discrimination and exclusion for Aboriginal people are largely unrecognized by mainstream society and health care services. Increased cultural safety and respect education and implementation are needed to address health professional attitudes and practices in responding to clients individual and cultural needs. Health professionals need to be directed and supported to modify external, generalisable, top-down practice directives that may reduce their capacity to recognise and meet individual client and family needs.

Finding ways to promote sustainability in a changing health system

In this era of mutual obligations and responsibilities, both mainstream and Aboriginal specific health services need to meet commitments made by them to community members, regardless of health system changes. Therefore, if a commitment is made that can no longer be met, active steps for seeking alternative solutions should be sought *in collaboration with community members*.

Implications for Aboriginal community women co-researchers

This research has signalled both benefits and losses for Aboriginal women co-researchers; in many ways it reflects the realities of their lives in postcolonial Australia. This research has provided an opportunity for their story to be heard and acknowledged in the context of what was happening at the time, instead of being misrepresented or unheard. The women tell me that the collaborative process has been very healing for them on many levels. They have come to understand the reasons behind events in health care and realise that what they interpreted as personal attacks, were sometimes unintended side effects of systems or program changes. They now realise that health professionals and even managers may not have control over how health services are provided, but that many will work with them to meet their needs as best they can. Making informed choices about the kind of health services they wish to attend, has also been a positive and self empowering experience that counters colonising and discriminating effects. The opportunity to create a women's friendship group and then decide themselves when it would finish was very

cathartic, particularly as they had been the recipients of uncommunicated health care changes for so long.

Importantly, this research was a positive research experience for the Aboriginal women and they have since become involved in other research projects. In a colonised country where western research is considered to be deeply untrustworthy, this is a significant achievement and indicates that this research process was both culturally and personally safe.

Implications for other Aboriginal women are that there are researchers, health professionals and Aboriginal and non-Aboriginal health services who are willing to work in respectful and collaborative ways to meet Aboriginal women's health and well being needs. Collaborative projects in health care and research can focus on and support Aboriginal women's strengths and abilities, rather than just focus on what is not working. Knowledge sharing models such as Ganma and Dadirri, and collaborative models such as our PAR are tools that can be used by both community women and health services to improve health and well being. They are accessible, understandable and support the need for personal and cultural safety.

Implications for health professionals practice

This research has highlighted the challenges and difficulties associated with trying to meet Aboriginal women's health and well being needs in urban primary health care settings. It has enabled the perspective of health professionals, particularly Aboriginal Health Workers and Nurses to be heard. This research has explored many issues that are also experienced by health professionals in a wider range of settings. These include; being blamed (or blaming self) when programs do not go to plan; Not having professional knowledge validated, recognised or included in health service delivery decisions; Working with people who are struggling with traumatic issues, and then experiencing vicarious trauma; Sweeping changes from comprehensive to selective primary health care; misunderstandings and frustrations experienced by health professionals and clients not understood by the wider health system; Having to walk away from health programs that are working well, or that were working well until they were dismissed or changed.

This research has highlighted the incredible work that many health professionals provide regardless and regardless of these issues. This research has developed a collaborative PAR that can be used as collaboration tool to improve health care experiences for both clients and health professionals *regardless* and *regardful* of what the health system is doing.

Implications for management

This research has not specifically focused on issues as perceived and experienced by managers, and this is an important area of research that needs to be considered further. During this research it was observed that onsite managers were often caught between local community and health service needs and the top down decisions being made by higher level managers, executive officers and policy makers. Using a postcolonial feminist perspective, I recognise that managers occupy powerful and powerless positions simultaneously.

In order for responsive comprehensive primary health care to be meaningfully implemented however, health service managers need to lobby for continuity of care and sustainability, and support and understand the complex issues that health professionals and clients deal with on a daily basis. Bottom up as well as top down decision making and policy processes need to be supported, with health professional and client knowledge recognised as crucial aspects of evidence based practice.

Implications for policy

There are many very good policies, frameworks and strategies that have not yet been fully implemented such as the National Strategic Framework and Strategies for Aboriginal and Torres Strait Islander Health 2003-2013 (2004), the Cultural Respect Framework (Australian Health Minister's Advisory Council 2004) and the Close the Gap Campaign (Oxfam Australia 2008). Increased emphasis needs to be placed on including end users in the formation of policies, and ensuring that policies can be effectively implemented. The experience of health professionals is that the time and complexities involved in effective implementation is often over looked.

Reflecting on the research process

In this project I have worked alongside Aboriginal and non-Aboriginal co-researchers and stakeholders to develop and implement a collaborative model of research in order to respond to the research questions and gaps in knowledge. This research has responded to questions raised during conversations and critical reflection of urban based Aboriginal community women and health and education professionals (Aboriginal health and education workers, nurses, doctors, teachers, counsellors) about how best to meet Aboriginal women's needs in our changing health environment. We sought to develop collaborative and culturally safe approaches enabling Aboriginal women, primary health care and education professionals, managers and organisations to work effectively together, to improve Aboriginal women's health and well-being.

Using my own postcolonial feminist nursing approach, I explored with others how health encounters can be spaces where two people come together bringing with them their own knowledge, beliefs, backgrounds and experiences; the health professional only brings half of the knowledge needed. Co-creating culturally safe research and collaboration processes was a major component of this project. Given the chequered history of Western research, and the health disparities that exist for Aboriginal people in Australia, it was important to find ways of working together that were both acceptable and effective. Our collaborative PAR achieved both of these aims. Blending together an already proven and easily understood approach, with local priorities and preferences, enabled us to modify PAR to meet local needs. Using processes of Ganma knowledge sharing and Dadirri deep and respectful listening enabled both Aboriginal and non-Aboriginal co-researchers to become actively involved in the creation of this research, and share ownership of it.

Strengths

A significant advantage of this form of research involved my positioning as a female nurse researcher, with already established working relationships with many of the co-researchers. These relationships enabled the research to progress in ways and speeds that would not otherwise be possible. As a nurse

researcher known by the community, I was perceived as trustworthy and appropriate by the co-researchers, particularly Aboriginal community women. They felt that my motivation for being involved in the research was more transparent, it was perceived to relate to my nursing role of improving health care for Aboriginal women. There were however advantages and disadvantages in the relationship of nurse researcher. At times ethical issues arose, and I had to choose between my nursing and research priorities.

As discussed, co-creating a collaborative PAR process increased ownership of the research by co-researchers and lessened the *threat* of research. Sharing roles in all stages of development increased opportunities for capacity building in group skills, decision making, negotiation, project planning, evaluation and public speaking. Using a range of methods, and encouraging co-researchers to choose which method they preferred to use and be involved in, reaffirmed these women's right to choose. Having opportunities to review transcripts from interviews and focus groups was also significant as a way for co-researchers to recognise their own knowledge and choose how, and in what form, they wished to share this knowledge with others. Drawing from postcolonial feminism enabled me to consider multiple perspectives and diversity. Rather than assuming homogeneity, unique needs and experiences were able to be recognised and accommodated.

Challenges

This research involved identifying and responding to the individual and collective needs of diverse groups of co-researchers and stakeholders. A possible disadvantage of working at one site was that this research presents a 'single' view of health care and collaboration, however generalisation was not intended and this project process may well be transferable to other settings. Working in collaboration across the four Collaboration Areas was challenging. I needed to increase my skills in flexibility, patience, trust in people and the PAR process, and believe in positive outcomes and our collective ability to create win-win solutions. This process required me to become comfortable with *not being in control* of the process. Specific challenges included being unable to work directly with the majority of young Aboriginal women in Collaboration Area Three due to changing youth programs and important

ethical requirements for research with young people in schools. I modified the purpose and focus of the Collaboration Area accordingly and began working with co-researchers who worked with young women, rather than the young Aboriginal women themselves.

There were specific challenges involved in researching and writing about Aboriginal health as a non-Aboriginal health professional. Working closely with Aboriginal mentor and researchers, and having Aboriginal health research ethical guidelines enabled me to ensure this research was as ethical, and culturally safe and respectful as possible. I took seriously my responsibility of conducting and co-ordinating the research, double checking research data and findings with co-researchers and stakeholders, and ensuring that research findings were disseminated widely in collaboration with co-researchers. The de-identification of data and safe storage and custody of data was also important.

Writing this research into a thesis that enabled co-researchers, mentors and stakeholders to access it, while still meeting academic guidelines has been another practical and intellectual challenge. However, in the interests of decolonisation and postcolonial feminist knowledge and power sharing, I believe this has been an important strategy.

Conclusion

This research has focused on collaboration as a pragmatic and necessary step toward Closing the Gap in Aboriginal women's health and well being. Over a period of four years I have worked with Aboriginal community women and health and education professionals to find ways that we can move forward together toward improving Aboriginal women's health and well being. Together we have highlighted the factors that impede effective collaboration and particular strategies to overcome these. Although this research focused on small groups of people connected to one urban setting, it has enabled specific issues to be identified and addressed through collaborative action. Our experiences have implications for health care and cross cultural interactions across a wider range of cross cultural and health settings. At the end of this research, we have established that our participatory action research can be used

as collaborative model of practice in a range of settings. It is a culturally respectful, practical, pragmatic and effective tool that can assist health practitioners and others to provide comprehensive primary health care for and with Aboriginal women in urban areas. Utilising our three central themes of knowledge sharing, working together and taking action we have been able to provide comprehensive and responsive health care *regardless* and *regardful* of health care trends. This has enabled us to Move Forward Together in improving Aboriginal women's health and well being.

APPENDICES

- Appendix 1 My Background and Motivation
- Appendix 2 Ethics Approval Letters (x3)
- Appendix 3 Support Letters
- Appendix 4 Research Study Information Sheet
- Appendix 5 Letter of introduction
- Appendix 6 Consent forms; adult, young women under 16 years (x3)
- Appendix 7 Trigger questions
- Appendix 8 Debriefing Material
- Appendix 9 Practitioner/Researcher Critical Analysis Tool
- Appendix 10 Moving Forwards Together Conference Program
- Appendix 11 Time + Respect = Trust Conference Presentation
- Appendix 12 Presentations and Publications arising from this research

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