



Effective Aboriginal community involvement in health planning: a case study

Judy Taylor, Centre for Rural Health and Community Development, Spencer Gulf Rural Health School, University of SA/Adelaide University, **Sue Edwards**, **Barb Carlin**, Wakefield Health, Yorke Peninsula SA, **Gary Misan**, **Christine Franks**, Centre for Rural Health and Community Development, Spencer Gulf Rural Health School, University of SA/Adelaide University, **Tania Angie**, Point Pearce Health Centre, **Sonia Campbell**, **C Lowings**, Centre for Rural Health and Community Development, Spencer Gulf Rural Health School, University of SA/Adelaide University, **Raymond Wanganeen**, **Ann Newchurch**, **Judy Walker**, Point Pearce Health Centre, **Julie Watkinson**, Centre for Regional Engagement, UniSA

Background

The Healthy for Life program funded by the Office of Aboriginal and Torres Strait Islander Health (OATSIH) provides, perhaps for the first time, something that Aboriginal and Torres Strait Islander communities and health services have been calling for – funding to address health and wellbeing issues in an interconnected and holistic way, using the best evidence and the ability to adapt initiatives to fit the local context.¹ Addressing health and wellbeing issues in a holistic way, which is the preference of most Aboriginal health services, requires integrated primary health care.² However, funding to support holistic service provision is not easy to obtain and health services are often in the situation of having to adapt program guidelines to suit their needs. The Healthy for Life program offers a rare opportunity for communities themselves to plan for integrated and preventative care.

In the first phase of the Healthy for Life program, funding is available to undertake community planning addressing chronic illness and improving maternal, perinatal, and child health care in a way that is integrated, uses best evidence, and is locally relevant. The second stage involves implementing the plans and evaluating processes and outcomes. This is in contrast to the more usual approach which is to target specific health conditions using pre-determined health care models. This new approach provides local organisations some flexibility in choosing which models they use and the conditions they will target but it introduces some specific planning challenges. The Wakefield Health Service commissioned the Centre for Rural Health and Community Development to assist in developing Stage 2 plans for the initiative.

The barriers to effective planning with communities for community-based health development have been extensively documented.^{3,4,5,6} While the literature about integrated primary health care planning with Indigenous communities is less comprehensive the following issues have been identified:

- It can be difficult to engage host Aboriginal or Torres Strait Islander communities in planning when cultural and family issues are uppermost and poor health is widespread. The burden of involvement usually falls on a few people who often have too many competing priorities. In such circumstances information may not reflect all the groups in the community.⁶
- It can be difficult to reach agreement on a definition of an Aboriginal community and who is to be included in the planning in a health region that is spread across a large geographic area. Health planners, community councils, community members, and administrators may all define the 'community' who is to participate in planning differently.⁷
- Inevitably there are different views and priorities in different communities and questions arise as to whose needs are paramount and how conflicting needs and priorities will be dealt with.⁸
- Finally, we know that ensuring the collaboration of a range of key stakeholders in the planning effort is recognised as essential to effective health care. But different stakeholders have different perspectives and the mainstream models of health care, rather than Indigenous, are dominant.⁹ Genuine negotiation of different perspectives may be perceived as too time consuming.

While we have an increasing evidence-base about Aboriginal and Torres Strait Islander health issues^{10,11}, we have less information to guide planning process and ensure that Aboriginal and Torres Strait Islander peoples, organisations, and communities have a say in how needs and priorities are determined and how services should be provided. This paper analyses planning practice in four areas:

- understanding the Aboriginal community
- establishing partnerships
- gathering information
- ensuring local ownership.

Setting

Wakefield is one of the former health regions in country South Australia covering approximately 24 000 square kilometres and includes the areas of Barossa and Light, Gawler, Lower North, and Yorke Peninsula. It has an estimated population of 116 674 people of which approximately 1100 (1.15%) identify themselves as Aboriginal and of whom the largest concentration (42%) reside within the Yorke Peninsula sub-region.

Wakefield Health provides a broad range of services through eight incorporated health services. While there is no community-controlled health service with resident general practitioners in the region there is an Aboriginal health centre at Point Pearce which provides a holistic health service with resident Aboriginal health workers and visiting general practitioners (GPs), allied health professionals, mental health professionals, and community nurses. There is limited data in the region that quantifies the burden of chronic illness for Aboriginal people or that demonstrates health service utilisation by Aboriginal communities. This makes community health planning for the Aboriginal population difficult.

Wakefield Health has done much to improve relationships with Aboriginal communities in its catchment area. For example, it has established the Wakefield Region Aboriginal Health Forum to provide advice to the Aboriginal Health Alliance and the Regional Board on issues relating to the health and wellbeing of Aboriginal people in the region. Also, the Wakefield Region Aboriginal Health Alliance (AHA), made up of representatives from the Wakefield Health Board and the Wakefield Aboriginal Health Forum, has been formalised with the development and signing of a partnership agreement. The aim of the AHA is to ensure that the expertise of Aboriginal people is recognised and effectively engaged in a partnership approach to the planning, delivery, monitoring and evaluation of culturally appropriate, equitable health and health related services and programs in the Wakefield region.

Aim

The aim of the Healthy for Life planning process was to produce a community owned plan to improve the long term health outcomes for Aboriginal people in the Wakefield health region. This paper analyses the developmental processes involved in obtaining community input.

The planning process

The conceptual frameworks

The conceptual frameworks used to undertake the planning were participatory action research (PAR)¹² and community capacity building.^{13,14}

- PAR¹² is a way of involving participants in addressing a real-life problem through a research process – in this case producing a community-owned plan to improve health. The PAR process involves community participation in all aspects of the research and providing feedback in a plan-action-review cycle.



- The community capacity building approach is well established in community health development and involves identifying and strengthening the relevant community capacities. Laverack's¹³ community empowerment framework was used as a basis of a questionnaire for community members to identify the communities' understanding of health issues, the organisations, networks, relationships available, and the level of awareness and readiness to engage in health development. In addition a specifically Indigenous¹⁴ capacity building model with four elements – building relationships, building skills, working together, and promoting commitment was used to guide the process.

The research team

As a first step the researchers were invited to visit the Narungga community to begin to establish relationships before any research could be considered. After introductions and an informal get-together, a meeting was held at Point Pearce Health Centre attended by seven community members, including the Aboriginal Manager of the centre and five SGRHS researchers. Discussions took place about what the community wanted and could get from the project and a firm decision was made to be involved. There had already been a number of health planning exercises completed and it was important to acknowledge this and not repeat work that had previously commissioned by Wakefield health.

Three respected members (one male and two female) of the community with a health background, but new to research were interested in working in partnership as researchers. They explained that they also planned to work in partnership with their community, using their expertise and knowledge of their own Aboriginal protocols and kinship. The research team then was made up of people who had intimate knowledge of the Aboriginal health issues in the region, the kinship networks and community dynamics, as well as people who had expertise in qualitative and quantitative research methods. Information was shared throughout the process through listening to each other and it was this blend of knowledge and skills that enabled the planning process to work.

Other participants

There were other important participants in the planning process including:

- Wakefield health service staff including community health
- members of the Wakefield Aboriginal Health Forum;
- Narungga people at Point Pearce, Moonta, and Kadina
- Kurna people at Gawler and Clare
- GPs involved in service delivery
- Yorke Peninsula Division of General Practice.

Information collected

Four sets of information were collected for the plan:

- demographic information was obtained from ABS and compared with community-based researchers mapping of family networks
- Wakefield service audit information and a process map
- clinical and health outcomes information for Aboriginal people in the region
- Aboriginal views about community capacity and health issues were gained from three focused group discussions with Narungga – Elders, men, women and young adults – at Point Pearce and a focused group discussion with Kurna in Gawler with 21 men and women of different ages attending. Five semi-structured interviews were also conducted.

Ethics

In this study, ethics approval was obtained through community consultation and negotiation. Community members were able to understand what the project was about and this led to a plan and approval of what the Narungga Aboriginal community defined as their issues. In the Wakefield area there is Narungga and Kurna land with different family groups, and spiritual and cultural traditions. Therefore, a Kurna representative on the Aboriginal Health Forum was approached for permission to plan with Kurna people and agreement was reached. This process ran parallel with application for formal ethics approval through the University of South Australia and the Aboriginal Health Council of South Australia. Ethics approval was obtained in May 2006.

Findings

Understanding the Aboriginal community

The term 'Aboriginal community' is constructed by non-Indigenous society for a variety of purposes, usually to bring Aboriginal and Torres Strait Islander people together as one group for ease of planning. In the Wakefield area it is difficult to talk of one 'Aboriginal community' given that there is Narungga and Kurna land with different family groups, and spiritual and cultural traditions. Before we could plan with 'the community' we needed to know how community was constructed by Narungga and Kurna across the geographic area. Then we needed to learn about the existing structures and networks that people used to share information and engage in health planning. At the broadest level the Aboriginal Health Forum was the appropriate structure.

At the local level the community researchers informed the team about the different family groupings. It was difficult to bring people together to plan because of long-standing and unresolved grief and loss issues. In Point Pearce for example, some places were seen as only appropriate for certain people, and while people acknowledged that they should own their own problems and find solutions it is very difficult in this small community to ensure that the people who have the skills and abilities are in a position to use them. There are many factors that prevent people coming together and some of these are difficult to discuss openly.

Establishing partnerships for planning

The researchers were invited by the Narungga people to visit the Point Pearce Aboriginal community with the senior Aboriginal researcher on the university team making the links. This visit was to build relationships and to establish whether or not the non-Aboriginal researchers who were not known to the community were credible. Once these relationships were established, a respected Narungga Aboriginal Health Manager introduced the researchers to the Kurna people. Further negotiation by the senior Aboriginal manager with the Kurna representative gained approval for the researchers to repeat some investigation of health issues that had previously been undertaken in that area. The non-Aboriginal researchers took no part in these negotiations but waited to be told what the next step with the employment and planning process would be.

Gathering information

The community-based researchers were keen to start on questionnaire design to gather information about community health issues and strengths. Four Aboriginal and three mainstream researchers developed a questionnaire adapted from Laverack's¹³ community capacity framework. This framework was chosen as a starting point because it was empowerment focused and would lead to obtaining information about community health issues and community strengths and capacities. This is in contrast to the situation where Aboriginal health is described as a series of problems and deficits and the solution is seen as providing more services rather than highlighting and documenting the strengths that Aboriginal people have to address these issues.

It was decided to ask existing groups whether or not the community-based researchers could attend and ask some questions about community health issues. The outcome of this was that four focused group discussions were held separately with men, women and their children, and Elders, in two locations in the region. Around 60 people that attended the group discussions were encouraged because these were culturally safe, led by trusted Aboriginal people, were built into every-day



activities, and included meals. Through this process, new links were made between people who did not normally see themselves as involved in health planning and who may not have been comfortable attending a health centre.

In addition to examining the community health issues the community-based staff undertook a count of family groups and residents in the Yorke Peninsula region based on their intimate knowledge of kinship networks and family groups. The researchers determined the number of family groups and then the number of people in these family groups. The figures were remarkably consistent with ABS and other figures for the region illustrating the intimate knowledge of the researchers about their people.

Some community members had a deep understanding of the health and the inter-relationships of poverty, loss of self esteem, drug and alcohol misuse, inappropriate use of health services, and how these factors impact on health.

Because of all these issues [loss of services, grief and loss, poor health] we are talking about it makes it very stressful, and it is sort of like one big circle isn't it? You go back and back to the same issues (Community member).

However, there were others who were not familiar with health terms in common use. The meaning of the term 'health' and 'wellbeing' and in particular the term 'wellbeing' was not understood by everyone. Therefore, it was necessary to ensure that everyone understood what the planning was about

An Aboriginal controlled process

Yes – the community should own their own problems – but it is going to be a hard road – there should be more encouragement.

Wakefield Health has sound relationships through the Aboriginal Health Forum and this ensured that planning process was controlled in a partnership between the Forum and Wakefield Health. For example, a draft plan was submitted to the Aboriginal Health Forum for their consideration of the options before it was presented to Wakefield Health. It was made very clear to the researchers that it was the Aboriginal Health Forum who was the important stakeholder in the process.

However, there are many other levels at which there need to be a sense of ownership and control of the planning process. At the local level there was widespread agreement that health improvement will only work if local people are involved in deciding what needs to be done. There was a view that community involvement and control of facilities and services would make their use more likely.

Things work best if the community are involved in organising it – that leads to them having control (Community member)

There were different views about how to achieve this and how much people are willing to get involved in changing things.

Discussion: implications for policy and practice

There is an expectation that planning with Aboriginal health about their issues will occur with the entire 'Aboriginal community'. This is justified by the fact that the problems are so serious and they are experienced differently in different contexts, and so it is important to really explore the issues. However, in this planning process ensuring involvement across the region was problematic. For various reasons there was a concentration of information about health issues in one area and involvement by Aboriginal people was not equitable across the region. To address this issue requires consistent relationship building over time with effective networks at the local level of people who are knowledgeable about health and wellbeing. The purpose and agenda of networks should be decided by Aboriginal people and resourced in such a way that they can achieve their aims.

Working together in a team with community-based Aboriginal researchers, and other researchers based in four locations, along with the Wakefield health staff presented logistical problems. It was easy for

some people to feel like they didn't know what was going on when there were problems with email, and telephones, and face-to-face communication was not always possible. We found that there is no substitute for face-to-face meetings and workshops between team members to build on relationships and ensure consistency of ideas and progress. Although such meetings are time consuming and costly when travel is involved they are essential and should always be costed into budgets.

There always remains the question as to whether Aboriginal health planning can be participatory at all levels. Structures such as regional Aboriginal health forums and boards are enormously helpful. But it is at the local level that diverse points of view will be presented from different cultural groups experiencing issues in different ways. Across the country there are the beginnings of structures and processes to address these issues which come about because there is not one 'Aboriginal community'.⁷ It is important that this information is shared so that we can learn from one another.

Conclusion

It is always important work in equivalent intercultural partnerships when planning for Aboriginal health. Structures such as regional Aboriginal health forums and boards are important and there are many other examples and opportunities for true partnerships. In this case study equivalent intercultural partnerships were achieved through the ethics process, employing community-based researchers, learning from community members about the structure of the community, and working together to collect data.

References

- 1 Atkinson R. Antenatal care and perinatal health: how to do it better in an urban Indigenous community. Good health – good country, Proceedings of 6th national rural health conference, Canberra: National Rural Health Alliance, 2001:85.
- 2 Genat WJ. Beyond the clinic, beyond the rhetoric: Holistic Aboriginal health worker practice at the margins. Unpublished PhD thesis. Perth: University of Western Australia, 2002.
- 3 Minkler M (ed). Community organizing and community building for health, 2nd edition. New Brunswick: Rutgers University Press, 2005.
- 4 Rifkin SB, Lewando-Hundt G, Draper A. Participatory approaches in health planning and promotion: a literature review. London: Health Development Agency, 2000.
- 5 World Health Organization. Primary health care 21: everybody's business: an international meeting to celebrate 20 years after Alma Ata, WHO Technical Report Series 809, Geneva: WHO, 2000.
- 6 Bartlett B, Duncan P. Top End Aboriginal Health Planning Study – Coledale: Health Plan Pty Ltd, 2000.
- 7 Taylor J, Wilkinson D, Cheers B. Working with communities in health and human services. Melbourne: Oxford University Press (in press).
- 8 Wilson J Remote Area Health Service Managers: Key Practice Issues, Australian Journal of Rural Health, 2001; 9(3)138–140.
- 9 O' Kane A, Tsey K. Shifting the balance: resources and services for people with mental illness in Central Australia. Darwin: Menzies School of Health Research, 1999.
- 10 Couzos S, Murray R. Aboriginal primary health care: An evidence-based approach. South Melbourne: Oxford University Press, 2003.
- 11 Trewin D, Madden R. The health and welfare of Australian Aboriginal and Torres Strait Islander peoples, 4704.0, Canberra: Australian Bureau of Statistics, Australian Institute of Health and Welfare, 2003.
- 12 Stringer E. Action research: A handbook for practitioners (2nd ed.), Thousand Oaks: Sage Publications, 2002.
- 13 Laverack G Building capable communities: experiences in a rural Fijian context. Health Promotion International. 2003;18(2);99–106.



- 14 Chino M, DeBruyn L Building true capacity: Indigenous models for Indigenous Communities. *American Journal of Public Health*, 2006;96(4):596-599.

Presenters

Barb Carlin is the Chief Executive Officer of Yorke Peninsula Health Service. She is responsible for Acute, Aged, Community and Corporate Services for a resident rural population of approximately 11 000 people, and visitors to the region in excess of 1 million per year. The Health Service employs 250 staff and has about 100 registered volunteers. Barb is also responsible for the Aboriginal Health portfolio for the county region of South Australia incorporating the areas of Yorke Peninsula, Barossa, Gawler and Lower North. Barb is an associate member of ACHSE.

Ann Newchurch is a Narungga woman from the Pt Pearce Community, which is situated on the Yorke Peninsula in South Australia. Ann is Chairperson of the Country Health SA – Clare Office Aboriginal Health Advisory Committee and Co-ordinator of Yorke Peninsula Health Service's Pt Pearce Health Centre. Ann has a strong background in Aboriginal health; having worked most specifically in the program and management fields, she is actively engaged in community issues at the local, regional and state levels and is a member of the Aboriginal Health Council of South Australia executive.