

An Evaluation Framework to Improve Aboriginal and Torres Strait Islander Health

Margaret Kelaher, Joanne Luke, Angeline Ferdinand,
Daniel Chamravi, Shaun Ewen and Yin Paradies

Centre for Health Policy
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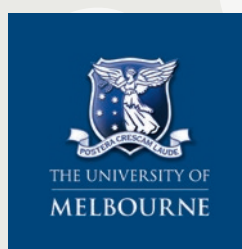
Report prepared for The Lowitja Institute

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Conflict of interest

The case studies were selected based on suggestions from the project reference group members and workshop participants. All suggested case studies were followed up and all those where a response was obtained in the timeframe of the project were included. Margaret Kelaher was on the evaluation team for the Sentinel Sites project. Community interviews for this project were collected by another team member to avoid bias.

Terminology

Throughout this report, the Indigenous peoples of Australia are collectively referred to as Aboriginal and Torres Strait Islander peoples. The terms *Aboriginal* and *Indigenous* are used when these are used in the original reporting, even when direct quotes are not used.

Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation	LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, Questioning and Intersex
ACCHS	Aboriginal Community Controlled Health Service	OCHRE	Opportunity, Choice, Healing, Responsibility, Empowerment)
ACCO	Aboriginal Community Controlled Organisation	MoU	Memorandum of Understanding
AH&MRC	Aboriginal Health & Medical Research Council	NACCHO	Aboriginal Community Controlled Health Organisation
CQI	continuous quality improvement	NHMRC	National Health and Medical Research Council
DYHS	Derbarl Yerrigan Health Service	PBS	Pharmaceutical Benefits Scheme
ED	emergency department	PRG	project reference group
ESP Project	Engaging Stakeholders in Identifying Priority Evidence-Practice Gaps and Strategies for Improvement	RCT	Randomised Controlled Trial
GP	General Practitioner	REACCH	Research Excellence in Aboriginal Community Controlled Health
HPF	Health Performance Framework	ScfC	Stronger Communities for Children
HREC	Human Research Ethics Committee	SSE	Sentinel Sites Evaluation
ICDP	Indigenous Chronic Disease Package	UNSW	University of New South Wales
IP	intellectual property	VACCHO	Victorian Aboriginal Community Controlled Health Service
IPAG	Implementation Plan Advisory Group		

Executive summary

Evaluation has the potential to benefit Aboriginal and Torres Strait Islander people through improved policy and programs. Evaluation also provides opportunities to harness and develop community expertise. However, communities, evaluators and government are concerned that evaluations of programs addressing Aboriginal and Torres Strait Islander health and wellbeing do not always deliver these benefits.

This project, An Evaluation Framework to Improve Aboriginal and Torres Strait Islander Health, aimed to develop a framework for the evaluation of policies, programs and services for Aboriginal and Torres Strait Islander peoples across Australia. The development of the framework was oriented towards improving the benefits of evaluation for Aboriginal and Torres Strait Islander people. The process focused on identifying the essential elements of evaluation planning and practice, and highlighting the requirements needed to undertake evaluations in this area.

The project addressed six key research questions to achieve these aims:

1. What are the key principles that should underpin evaluation of any policy, program or service aiming to improve Aboriginal and Torres Strait Islander health and wellbeing?
2. What would be the key elements—for example, governance and funding arrangements—in a systems-based framework to guide evaluations of policy, programs and services whose goals are to improve Aboriginal and Torres Strait Islander health and wellbeing?
3. What would be the key elements required to support and advance Aboriginal and Torres Strait Islander community-level engagement in relation to policy, programs and services evaluation to inform local decision-making processes?
4. Are there key ‘indicators’ or evaluation questions for which data could be collected relevant to each identified element at the different levels?
5. What would good practice evaluation at a policy or program level encompass?
6. Are there examples of program evaluations that have demonstrated good practice and what are the elements of these?

The project was conducted from September 2016 to December 2017. Activities focused on identifying the extent to which past evaluations delivered benefit to Aboriginal and Torres Strait Islander communities and identifying promising strategies to improve benefits. The project also identified areas where the ability of evaluations to deliver benefits could be strengthened, such as:

- increasing transparency and accountability
- incorporating principles for working with Aboriginal and Torres Strait Islander people into programs
- using ethical frameworks that recognise the responsibilities of all parties in evaluation
- supporting Aboriginal and Torres Strait Islander leadership and ownership at all phases of the program planning and evaluation cycle.

Overall, the project found a high level of recognition of limitations of current practice from a range of perspectives. The will to improve practice was reflected in positive initiatives to address these limitations. However, there was also recognition that systemic change is required to fully implement the changes required to improve the benefits of evaluation for Aboriginal and Torres Strait Islander communities.

The evaluation framework

The project developed an evaluation framework to improve benefits to Aboriginal and Torres Strait Islander communities. The framework has two parts. Part A outlines *what* to evaluate and Part B outlines *how* to evaluate:

- Evaluation framework to Improve Aboriginal and Torres Strait Islander Health, Part A: What to evaluate—key principles and indicators of programs
- Evaluation framework to Improve Aboriginal and Torres Strait Islander Health, Part B: How to evaluate—adaptation of the research for a health justice framework.

Part A of the framework is presented in Table 5 (Chapter 4) and is a guide to the stated principles of Australian governments for working with Aboriginal and Torres Strait Islander people. The principles, which are described in Table 5 and include outcomes and indicators, are:

- partnerships with Aboriginal and Torres Strait Islander organisations and communities
- shared responsibility
- engagement with Aboriginal and Torres Strait Islander people and communities
- capacity building of Aboriginal and Torres Strait Islander communities
- equity
- accountability
- evidence based
- holistic concept of health
- cultural competence
- data governance and intellectual property
- capitalising on Indigenous strengths.

These principles should underpin any policy, program or service that aims to improve Aboriginal and Torres Strait Islander health and wellbeing and should be included as part of the evaluations for such initiatives.

Part B of the framework (Table 6) shows the tasks that should be completed:

- developing programs to improve Aboriginal and Torres Strait Islander health
- implementing programs to improve Aboriginal and Torres Strait Islander health
- evaluating programs to improve Aboriginal and Torres Strait Islander health
- knowledge translation.

Table 6 also shows who (evaluators, commissioners or program implementers) has predominant responsibility in current evaluation models.

The framework (Parts A and B) seeks to promote accountability around principles for working with Aboriginal and Torres Strait Islander people through evaluation and to ensure that ethical responsibilities in evaluation are allocated to those most capable of performing them.

Recommendations

The project identified barriers that prevent the evaluation of programs to address health and wellbeing among Aboriginal and Torres Strait Islander people from optimally benefitting those communities. It also identified promising initiatives and exemplars that suggest ways to improve practice. This project makes the following recommendations for an evaluation framework to improve Aboriginal and Torres Strait Islander health and to ensure tangible benefits from the policies, practices and services designed to improve the health of Aboriginal and Torres Strait Islander communities.

Transparency and accountability around Aboriginal and Torres Strait Islander health evaluations should be improved by ensuring access to tender documents, evaluation reports and documentation of responses to evaluations.

The project has reviewed all evaluations of programs addressing health and wellbeing among Aboriginal and Torres Strait Islander people where a request for tender was publicly advertised in the past ten years. Direct requests were made to tenders sites, relevant websites and databases, which were searched and listed contacts individually followed up. Only 5 per cent of tender documents and 33 per cent of evaluation reports were able to be obtained. Positive initiatives are underway to ensure that evaluation results are released. However, this should be expanded to include past evaluations. Documenting responses to evaluations and making these available is also crucial to transparency and accountability and in communicating benefit to Aboriginal and Torres Strait Islander communities.

Evaluations of programs addressing Aboriginal and Torres Strait Islander health and wellbeing should use the framework to address government principles for working with Aboriginal and Torres Strait Islander people.

All Australian governments have developed principles for working with Aboriginal and Torres Strait Islander people. These should be incorporated into all programs and could therefore logically be expected to be reflected in evaluations. Part A of the evaluation framework outlines indicators that can be used to assess this but evaluators should use whatever is most appropriate to the local context. If particular principles are not invoked in a program, this should be noted.

Evaluations of programs addressing Aboriginal and Torres Strait Islander health and wellbeing should use ethical frameworks that recognise the responsibilities of all parties in evaluation and make optimal use of their capabilities to deliver health benefit.

Benatar and Singer (2000) have proposed ‘a new, proactive research ethics concerned with reducing inequities in global health and achieving justice in health research and health care’ (pp825). These new ethical frameworks for ensuring that research and evaluation deliver health justice identify specific obligations for commissioners, evaluators and program implementers (Ruger 2009). Parties are assigned obligations because the functions they typically assume make them particularly capable of fulfilling the obligations (Pratt & Hyder 2015; Pratt & Loff 2014). This approach expands upon but is not inconsistent with existing approaches to ethics in Aboriginal and Torres Strait Islander health (NHMRC 2003, 2010).

Aboriginal and Torres Strait Islander leadership and ownership should be supported at all phases of the program planning and evaluation cycle.

There is strong recognition that Aboriginal and Torres Strait Islander people need to be involved in program development and evaluation. However, this often consists of consultation rather than leadership roles. Where Aboriginal and Torres Strait Islander leadership is recognised, it is more likely to be at local levels of decision making, often when program parameters have already been defined. Meaningful engagement of Aboriginal and Torres Strait Islander people at any point in the program planning and evaluation cycle will add value. However, improving the benefit delivered through evaluation to Aboriginal and Torres Strait Islander people will require a systemic approach to engagement that enables both leadership and ownership.

Supporting the recommendations

Tender processes should support evaluation proposals that are most likely to benefit Aboriginal and Torres Strait Islander people.

The tender process provides commissioners with an opportunity to define their preferences in the conduct of an evaluation and the criteria against which evaluators are selected. This is a powerful agenda-setting activity in any evaluation. Defining selection criteria around the benefit provided to Aboriginal and Torres Strait Islander people would strengthen this imperative in evaluation.

Evaluation contracts and agreements should be consistent with principles for working with Aboriginal and Torres Strait Islander people and ethical frameworks.

Evaluation contracts, particularly around intellectual property, are often at odds with community expectations and ethical frameworks. They are also primarily between the commissioner and the evaluator. Evaluators and the community may have their own agreements, although these in turn need to be consistent with contractual arrangements. There is often no clear pathway for community access to evaluation data, although under ethical frameworks they would be expected to ‘own’ this data. Developing contracts and agreements that support community engagement and ownership of data would improve benefits to Aboriginal and Torres Strait Islander people and align contracting with ethical frameworks.

Tender documents, evaluation reports and responses to evaluation should be stored on a publicly accessible database.

Tender documents, evaluation reports and responses to evaluation should be stored on a publicly accessible database. If there are sensitive issues about the release of some information, it can be embargoed for a period of time. The Australian Indigenous HealthInfoNet is comprehensive, well regarded and authoritative in its reviews of policy, but its utility is limited to what is available on government websites. (Note: the Australian Indigenous HealthInfoNet also includes peer-reviewed literature but this is not subject to the same concerns.) Expanding the Australian Indigenous HealthInfoNet to include direct archiving may assist in enabling ongoing access to the evidence base.

Past evaluation reports should be released.

Past evaluation reports should be released so that the evidence base around policy and programs is more transparent.

A directory of current evaluations should be developed.

Developing a directory of current evaluations would help address issues around the level of evaluation in Aboriginal and Torres Strait Islander health and wellbeing. It would also provide a platform for commissioners, communities and evaluators to share learnings.

Evaluation data should be stored so that they are accessible to the communities in which data are collected, and local data management/analysis capability should be supported.

Ideally, Aboriginal and Torres Strait Islander communities should host repositories for their own data. However, considerable capacity building would be required to make this possible. In the interim, hosting data with a third-party organisation should be considered. Any such arrangement would have to respect data sovereignty, as well as security.

Training opportunities should be provided to support Aboriginal and Torres Strait Islander leadership in evaluation and participation in co-design.

Training to specifically support Aboriginal and Torres Strait Islander leadership in evaluation will improve benefits to the community both through employment and by improving evaluation itself. Aboriginal Community Controlled Health Organisations (ACCHOs) have a potential leadership role in promoting better incorporation of principles for working with Aboriginal and Torres Strait Islander people. Primary Health Networks may be well placed to support training opportunities.

Longer-term partnerships should be developed to support Aboriginal and Torres Strait Islander leadership in evaluation and participation in co-design.

Optimally, supporting a greater focus on co-design and the associated investment in training may require the development of longer-term partnership arrangements with communities. These could potentially be supported at regional level with support from Primary Health Networks and ACCHOs.

Evaluation reports should report against principles for working with Aboriginal and Torres Strait Islander people both in terms of the program and evaluation itself.

Clear reporting against principles for working with Aboriginal and Torres Strait Islander people would help develop the evidence base around the application of these principles.

Evaluation reports should report against ethical frameworks both in terms of the program and evaluation itself.

Clear reporting against ethical frameworks would help develop the evidence base around the application of these frameworks.

New models of developing programs and evaluations should be considered.

The project primarily considered evaluations where the evaluator was commissioned to complete an evaluation after a program was developed. A number of emergent approaches to program development and evaluation are more closely embedded within communities.

1. Introduction

The question of how to achieve equitable health outcomes for Aboriginal and Torres Strait Islander communities has underscored significant policy, program and service delivery development over the past decades. Research and evaluation are recognised as essential aspects in improving Aboriginal and Torres Strait Islander health policy and practice. However, there continue to be gaps in the evidence base for improving Aboriginal and Torres Strait Islander communities' health, leading to consistent calls for rigorous evaluation to inform the design and development of new approaches. Moreover, questions have been raised about the utility, effectiveness and ethics of the research and evaluation undertaken in Aboriginal and Torres Strait Islander health (Bainbridge et al. 2015), leading to reconsideration of the purpose of health program evaluation in this area. Ensuring that Aboriginal and Torres Strait Islander communities receive tangible benefits from the policies, practices and services designed to improve their health necessitates identifying and embedding best practice in evaluation of Aboriginal and Torres Strait Islander health programs.

Determining best practice in health program evaluation

The role of evaluation

Evaluation has long been recognised as a crucial component of effective health policy and program development. When well utilised, evaluation allows for assessment of program success and transparency and for strengthening the evidence base, which then feeds into the generation of future interventions. However, when poorly done, evaluation may be, at best, a waste of resources if the results are not taken up or, in the worst case, may cause harm if negative program outcomes and their causes are not identified and are allowed to be replicated in subsequent interventions. There has been concern that evaluation in Aboriginal and Torres Strait Islander health has not always lived up to its promise (Bainbridge et al. 2015). The focus of this report is around identifying strategies to improve the benefit of evaluation to Aboriginal and Torres Strait Islander communities, noting that, as with all evaluations, the associated benefits are contingent on the quality of the evaluation.

Assessment of the state of health program evaluation must begin with an understanding of its expected contribution to health policy and practice. At a systems level, good evaluation is a critical dimension of evidence-based decision making because it both generates and utilises information about intervention effectiveness and feasibility. Figure 1 shows the program planning and evaluation cycle. Evaluation planning

should be undertaken alongside program design from the first stages (PM&C 2017). This allows the evaluation to be developed in relation to the objectives and goals of the program itself and ensures that the evaluation questions are of relevance to those who will eventually utilise the findings. At these early stages, underlying theories regarding the causal pathways of the program should also be clarified and the evaluation methodology should be designed to test these theories and answer key questions. At this point all stakeholders should be involved to build a shared understanding of the purpose of the program, the resources that are available (including financial resources, time and skills) and how these resources will be utilised to achieve the program goals. For this reason, engaging stakeholders is often seen as the first step in an effective evaluation process to ensure that the needs, expertise and perspectives of all parties are represented at the earliest stages (Centre for Epidemiology and Evidence 2017; Greene et al. 2006). These early stages should also identify and utilise available evidence to strengthen both the program and evaluation.

As the program is implemented, opportunities for evaluation data collection and timely feedback of initial findings strengthen service delivery as unintended consequences are identified early and strategies refined in response (PM&C 2017). As data collection, monitoring and feedback are undertaken jointly, there is a shared understanding of what is being evaluated and why. Analysis and feedback are conducted in ways that are useful for program implementers and other stakeholders.

Following the evaluation, findings should be placed to support improved future policy and program development; that is, the evaluation findings of one program should be embedded into the decision-making cycle as part of an iterative process (PM&C 2017). This requires the engagement of stakeholders, policymakers and end users from the initial stages of the program and evaluation design to ensure that the evaluation outcomes are useful, understood and accessible. Given the role of evaluation in building the evidence base through iterative cycles of program development and evaluation, assessing the quality of health program evaluation must be undertaken at two levels: good practice in evaluating an individual program and the contribution of evaluation findings to further development.

The question of what constitutes good practice in health program evaluation is not straightforward. Health programs, policies and interventions vary widely in terms of their targeted populations, scope, expected outcomes and approaches, which necessitates an equally diverse repertoire of evaluation strategies. The complexity and diversity of applied programs has prompted a move towards evaluation that considers the many



Figure 1: Program planning and evaluation cycle

factors that affect the success of programs in the real world. In black box approaches, an evaluation is primarily concerned with assessing the outcomes of a program to determine whether it has achieved its objective, with little attention to the mechanisms via which this has been achieved. This contrasts with theory-driven approaches, which consider, as part of the evaluation, the mechanisms and rationale behind the program itself (Chen & Rossi 1989).

Theory-driven evaluation sees part of the role of evaluation as testing whether the theorised pathway between a program's inputs, outputs and objectives is valid (Chen 2012). From this perspective, health program evaluation is concerned not only with whether the program worked but how and why (or why not). The use of a program logic that makes the theory behind the program activities and outcomes explicit serves to improve methodological rigour in the evaluation as theorised causal mechanisms and contextual factors are taken into consideration in developing evaluation strategies (Chen 2012). The links in the causal chain itself can therefore be evaluated and understanding of the factors that affect a program's success strengthened, possibly increasing the transferability of the evaluation results. If unintended effects are identified, having an

explicit theory regarding how the program is expected to work may support localising how and why the effects have occurred. Use of a program logic also helps to ensure that the evaluation is focusing on the aspects of the program that are most likely to be of relevance and interest (CDC 2011; Chen n.d.). For these reasons, evaluation and program development are closely intertwined; consideration of the structure and design of the evaluation alongside that of the program allows synchronous and mutually supportive practice in both.

Principles of best practice

As mentioned, due to great diversity across health programs and their evaluations, there are difficulties in determining whether an evaluation is well designed or effective. Evaluation traditions focus on different elements of evaluative practice; in the 'evaluation theory tree', where authors attempt to map different evaluation theories in relation to each other, Christie and Alkin (2008) designate branches of the tree to evaluation theorists who have been influential in the field. These theorists are arranged around three main branches, depending on the aspect of evaluation that most concerns them: the *methods*

used in evaluation, the *values* by which data are judged and the *use* of evaluation. There are therefore tensions between evaluators about what matters most in judging the quality and conduct of an evaluation. The development of guidelines to assist in the production of high-quality evaluations therefore necessitates finding sufficient similarities within the diversity of health programs and the corresponding evaluations to allow a set of principles to be applied across this spectrum.

In response to increasing pressure to demonstrate the effectiveness of health promotion initiatives, the World Health Organization European Working Group on Health Promotion Evaluation was convened in 2001 to examine evaluation theory and best practice in this field (Rootman et al. (eds) 2001). The aim was to support practitioners and evaluators through the production of guidelines and resources. The Working Group commissioned more than 30 background papers to be reviewed by a range of individuals and groups with experience in health promotion. The Working Group concluded that four core principles should guide evaluation of all health promotion initiatives (Rootman et al. (eds) 2001):

1. Participation of entities with an interest in the initiative, including policymakers, community members and organisations, and health agencies, with a particular emphasis on the participation of members of the community who are affected by the intervention.
2. Interdisciplinarity, utilising a range of methods and strategies for gathering and analysing data.
3. Capacity building of individuals, communities and governments.
4. Appropriate design that is responsive to the complexity of health promotion initiatives and sensitive to long-term impacts.

The Working Group noted the importance of recognising ‘valuing’ in evaluation—that is, the process by which elements are deemed to contain value. Rather than the facts or information collected in evaluation being value-free, these are assigned value as part of the evaluation due to:

- the program being evaluated having its own inherent sets of values
- the influence of evaluation outcomes on resource allocation and decision making, which also bear their own sets of values
- the process of data analysis and interpretation necessitating the determination of values in order to elicit meaning (Greene et al. 2006; Rootman et al. (eds) 2001).

The assignment of values is therefore intimately tied to the use of knowledge generated by evaluation in decision making about programs and policies (Rootman et al. (eds) 2001).

The use of evaluation findings in the design and development of future programs and policies is fundamental to the purpose of health program evaluation; nevertheless, a gap between the generation of knowledge and its use persists. Several reasons have been identified for this, including the independent manner in which researchers and decision makers operate; limited opportunities for information exchange and communication; and a focus on the dissemination of information at the expense of consideration of uptake (Lomas 1997). King et al. (2013) tie together the valuing process and address the identified gap between knowledge creators and knowledge users. They examine methods of systematically approaching the issue of valuing in evaluation, aiming to be more transparent about how judgments are made about quality, utility and effectiveness, as well as about who should be involved in making these judgments. They find that being transparent about differing viewpoints and values, and about how these impact evaluative judgments from the beginning, improves the probability that evaluation findings will be accepted. In this consideration, they note the importance of bringing funders, communities, evaluators and stakeholders together early in the process to increase shared understandings of what matters (King et al. 2013). In response to similar concerns and following two major reviews of how research knowledge is used by decision makers, Mitchell et al. (2009) also consider how to reduce the distance between health services research and the use of available evidence through the use of various partnership models. The authors conclude that different types of partnerships may be necessary to accommodate variations in the policymaking environment, but an important element is having ‘diffuse and heterogeneous linkages’ (pp104) between researchers and decision makers, as well as considering knowledge creation and knowledge utilisation as different elements present in a shared epistemic culture (Mitchell et al. 2009).

Countering each of these limitations necessitates the development and use of evaluation methods that can respond to a variety of settings and incorporate an understanding of processes that occur between the inputs and outputs of a program (Shelton 2014). Questions regarding the feasibility and sustainability of a program will require a different set of skills from evaluators than attempting to determine the reach or cost-benefit ratio of an intervention, which points to the utility of interdisciplinary evaluator teams.

Evaluation practice in Aboriginal and Torres Strait Islander health

Effective evaluation practice supports the objective of equitable health for Aboriginal and Torres Strait Islander communities through multiple pathways. Well-executed evaluations increase the efficiency and effectiveness of existing resources by signalling the initiatives that are likely to be beneficial. This is particularly relevant given the lack of resources that often characterises the Aboriginal and Torres Strait Islander health sector (Panaretto et al. 2014; Dwyer et al. 2009). The evaluation of programs, policies and services that aim to improve Aboriginal and Torres Strait Islander health is crucial for providing information about successful strategies and approaches, as well as factors that contributed to success. As a corollary to this, data on what has not worked and why is also valuable to reduce future waste in repeating resources that are unlikely to be successful (Halliday & Segal 2012). Having this information helps to reduce unintended negative consequences of policies, programs and services over time and to increase the probability that programs will be appropriate and effective. Evaluation increases transparency and accountability in the whole Aboriginal and Torres Strait Islander health sector by providing an account of how resources have been utilised and clarity around current practice and how it has evolved. Evaluation also increases transparency at the level of individual programs by making the goals, objectives and theorised pathways between each of these and the actions undertaken within the program explicit through the use of program logics. In the case of Aboriginal and Torres Strait Islander health programs, this enables the examination of whether and how a program incorporates principles such as community engagement or a holistic concept of health and equity, and the contribution of these elements to the program's success.

However, potential benefits from evaluation in Aboriginal and Torres Strait Islander health are yet to be realised. While there is no consensus regarding the proportion of Aboriginal and Torres Strait Islander health programs that are evaluated, evaluation quality is generally reported as being quite poor and there are significant difficulties in accessing evaluation results (Lokuge et al. 2017; Hudson 2017). Of the evaluations that are reported, few consider the transfer and implementation of programs across different sites or groups. This indicates a gap in the knowledge of how to improve the health of Aboriginal and Torres Strait Islander communities through the successful adoption of promising and evidence-based initiatives (McCalman et al. 2012).

In 2012 the Australian Government Productivity Commission held a policy roundtable with key stakeholders on the importance of policy, service and program evaluation to help improve health outcomes for Aboriginal and Torres Strait Islander people (Productivity Commission 2013). Areas identified as needing to be addressed included:

- the lack of basic information about existing programs, including their objectives and associated program logic at the local, state and territory, and federal levels
- the lack of a coherent framework for the evaluation of Indigenous policies and programs, and a need to embed (and fund) evaluation plans in the design of programs
- the need for genuine partnership between governments and Indigenous communities and organisations in the development and evaluation of programs and policies
- the influence on Indigenous policies and programs of various aspects of governance, such as government silos, program duplication, red tape, lack of government staff competencies, piecemeal and short-term funding, and lack of flexibility
- the failure to adopt known success factors and follow lessons painfully learned over many years of policy experimentation.

The principles identified as being central to good health program evaluation practice in general are equally as critical to evaluation of programs, policies and services designed to address Aboriginal and Torres Strait Islander health. The importance of community engagement, capacity building, and flexibility and robustness in evaluation design has been repeatedly highlighted (Lokuge et al. 2017; Hudson 2017). While effective evaluations are essential for demonstrating whether programs designed to improve Aboriginal and Torres Strait Islander health are delivering benefit to the community, the question of the benefits that are expected may not be straightforward. A program may be designed and developed without adequate input from the Aboriginal and Torres Strait Islander community it aims to benefit and therefore may not address the health priorities relevant to the community. Alternatively, it may address a health issue in a way that is contrary to community norms or values. If designed without leadership from the affected community, a program runs the risk of consuming community resources, including time, without delivering benefit as defined by the community itself.

Logically, when evaluating a health program, the structure and implementation of the evaluation is closely connected to the design, purpose and implementation of the program itself as the evaluation normally aims to assess whether the program has achieved its predefined objectives. Therefore, the evaluation of a program that has been designed around objectives that are not in line with Aboriginal and Torres Strait Islander community priorities and values will struggle to incorporate these perspectives into the evaluation. In such a case, while an effort may be made to strengthen the inclusion of community perspectives in the evaluation, this is likely to be difficult, particularly if the aims of the evaluation are established by the same body that designed the program. Relatedly, if a program has been designed and implemented without

sufficient Aboriginal and Torres Strait Islander engagement, the evaluation is also likely to have the same fault.

The identified failure to incorporate lessons learned through previous evaluation illustrates that the same gap between evidence generation and utilisation persists in Aboriginal and Torres Strait Islander health (Productivity Commission 2013). The involvement of evaluators in the initial stages of design and development of health programs may encourage the inclusion of evidence regarding best practice from the beginning (Ferdinand, Paradies & Kelaher 2017). Moreover, better integration between evaluation and program design allows for more coherent planning regarding data collection, which serves to minimise the burden on participating communities and may support more efficient uptake of evaluation findings by funding bodies, policymakers, implementers and other stakeholders. The disjunction between evaluators and those who would be expected to utilise evaluation findings, coupled with the need to incorporate community perspectives into program and evaluation design, implies that partnership development and capacity building to enable community participation will be essential to good practice in evaluating Aboriginal and Torres Strait health policy. At the same time, the complexity of factors that affect the success of Aboriginal and Torres Strait Islander health programs, policies and services necessitates robust evaluation design that incorporates a range of methods and strategies (Hudson 2017; Productivity Commission 2013).

Ethical evaluation practice

In the case of evaluation of Aboriginal and Torres Strait Islander health programs, policies and services, the central principles are not only a question of good evaluation practice—they also intersect with ethics in Aboriginal and Torres Strait Islander health research as laid out in two National Health and Medical Research Council (NHMRC) publications, *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research* (NHMRC 2003) and *Keeping Research on Track: A Guide for Aboriginal and Torres Strait Islander Peoples about Health Research Ethics* (NHMRC 2010). These guidelines lay out the following key ethical values:

- spirit and integrity
- reciprocity
- respect
- equality
- survival and protection
- responsibility.

Aboriginal and Torres Strait Islander governance and community consultation in program design and delivery, as well as collaboration between mainstream and Aboriginal Community Controlled Organisations (ACCOs), are considered key pillars of ethical evaluation. Other ethical concerns include the protection of Aboriginal and Torres Strait Islander intellectual property, self-determination, cultural competence, identifying stakeholders and unethical timelines (Williams, Guenther & Arnott 2011). The need for greater capacity within Aboriginal and Torres Strait Islander communities and organisations to conduct effective program evaluation and appropriately utilise evaluation evidence has also been identified (Empowered Communities 2015).

Ethics in evaluation have largely been conceptualised around the relationship between the evaluators and participants or community members, with responsibility for ethical conduct falling on researchers, such as in the NHMRC guidelines (NHMRC 2003). However, this framing is problematic because many benefits of evaluations depend on the appropriate involvement of other stakeholders (Hudson 2017). For example, the application of evaluation findings to future program and policy development relies on evaluation commissioners making the findings public and accessible in the first instance, and on policymakers and program designers incorporating evaluation results in decision-making processes. Furthermore, the conduct of research does not solely depend on researchers—it is also heavily influenced by the terms of contracts between funders and researchers. Fulfilment of ethical responsibility in Aboriginal and Torres Strait Islander health programs, policies and services therefore needs to incorporate an understanding of the role of all stakeholders, including funding bodies, program implementers and research institutions.

Currently, there is a need for a framework to guide the ethical evaluation of policies, programs and services that aim to address Aboriginal and Torres Strait Islander health. In considering the principles to be applied across such evaluation, a framework would incorporate an understanding of the particularities of this evaluation as opposed to other types of research, including the relationships between Aboriginal and Torres Strait Islander communities, program implementers, evaluators, evaluation commissioners and policymakers. It would also need to integrate principles of Aboriginal and Torres Strait Islander research and centre the engagement of Aboriginal and Torres Strait Islander communities in evaluation. This framework would be systems-based in that the differing levels across which evaluation takes place would be acknowledged, as well as the necessity to consider that the appropriate use of evaluation results depends on actors placed in diverse sectors both within and outside the health system.

2. Project aims

This project aims to develop a coherent evaluation framework to guide the evaluation of policies, programs and services designed to address the specific needs of Aboriginal and Torres Strait Islander people across Australia. The framework is oriented towards improving the benefits of evaluation for Aboriginal and Torres Strait Islander people. The framework aims to identify the essential elements of evaluation planning and practice and to highlight requirements in undertaking evaluations in this area.

The project aims to answer six key research questions:

1. What are the key principles that should underpin evaluation of any policy, program or service aiming to improve Aboriginal and Torres Strait Islander health and wellbeing?
2. What would be the key elements—for example, governance and funding arrangements—in a systems-based framework to guide evaluations of policy, programs and services whose goals are to improve Aboriginal and Torres Strait Islander health and wellbeing?
3. What would be the key elements required to support and advance Aboriginal and Torres Strait Islander community-level engagement in relation to policy, programs and services evaluation to inform local decision-making processes?
4. Are there key 'indicators' or evaluation questions for which data could be collected relevant to each identified element at the different levels?
5. What would good practice evaluation at a policy or program level encompass?
6. Are there examples of program evaluations that have demonstrated good practice and what are the elements of these?

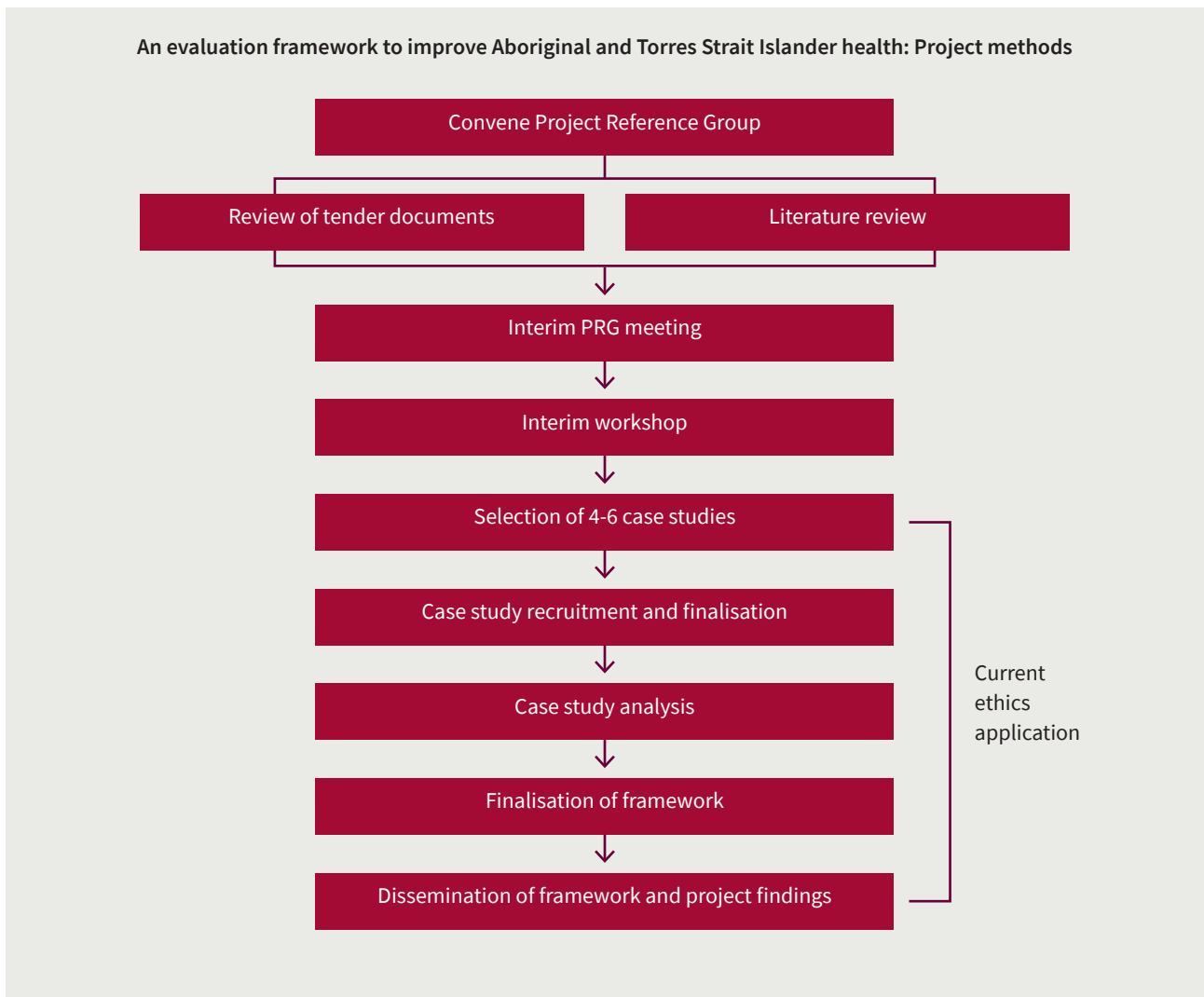
This report refers to a number parties involved in evaluations.

- Evaluation commissioners—the organisations that fund evaluations and, in most cases, are responsible for the program being evaluated. In some cases they are independent of the program but because this is a relatively unusual arrangement, we assume, in this report, that commissioners have responsibility for both programs and evaluations. However, where there is independence, responsibilities should be attributed to the appropriate party. Programs are multi-level such that the organisations responsible for a program often differ from the organisations responsible for implementing them.
- Program implementers—the organisations responsible for implementing a program in a particular setting. While they may have management responsibilities in that setting, they do not have overall responsibility for the program.
- Evaluators—the organisations responsible for the evaluation.

3. Project methods

The project was conducted from September 2016 to December 2017. Figure 2 outlines the process for the development of the framework, including the consultative processes.

Figure 2: Process for developing the framework



Project reference group

A project reference group (PRG) was set up at the initial stage of the project to help guide the development of the evaluation framework. The PRG included key experts and representatives from agencies most likely to incorporate project findings into policy, including professionals who commission, conduct and utilise evaluations. It included representation from Aboriginal Community Controlled Health Organisations (ACCHOs), the Lowitja Institute, the Department of Health, the Department of the Prime Minister and Cabinet, and the Productivity Commission.

The PRG's focus was to:

- guide the development of the evaluation framework in terms of principles in Aboriginal and Torres Strait Islander health and wellbeing that inform what should be evaluated and how evaluations should be conducted
- identify tenders, tools or evaluations as exemplars that constitute best practice in evaluations of programs and policies addressing Aboriginal and Torres Strait Islander health and wellbeing
- inform directions of the project
- further develop feedback and communication strategies.

An initial PRG meeting was held following consultations with evaluators, policymakers and ACCOs. Following these consultations, it seemed that many of the issues inhibiting the development of better evaluation practice and action from evaluations have been well documented. A possible exception was concern by policymakers about a lack of knowledge in relation to Aboriginal and Torres Strait Islander program

evaluation among commissioners of evaluation. Accordingly, the project design shifted focus to allow more comprehensive consultation around the development of frameworks. A second PRG meeting was held in November 2017 to provide feedback on revisions made following the workshop.

Document review

Literature review

To develop an evaluation framework of policies, programs and services to improve Aboriginal and Torres Strait Islander peoples' health and wellbeing, a comprehensive review of the peer-reviewed literature was conducted to ensure that the project was based on the most up-to-date best practice research. Studies that evaluated Aboriginal and Torres Strait Islander health programs, services or policies were included in this review.

Relevant studies were identified by searching three electronic databases: Medline (Ovid), Scopus and ATSIhealth (Aboriginal and Torres Strait Islander Health Bibliography) (Table 1). Medline (Ovid) and Scopus are general databases, and ATSIhealth covers Indigenous and health-related literature. The search terms used for Medline (Ovid) and Scopus were '(Aboriginal or 'Torres Strait Islander*' or indigenous) and Australia AND policies or policy or program* or service* or intervention* AND health or wellbeing or well-being AND evaluation *'. The ATSIhealth database is more specialised, so the search terms were limited to 'evaluation'. Table 1 shows the results of the search strategy for each database. An EndNote library has been maintained, containing all utilised references, as well as attached PDF documents. Once duplicates were removed, a total of 102 articles were retrieved and 81 were included in the full review.

Table 1: Results of the literature search (2007 to January 2017)

Database	Search strategy	Abstracts retrieved	Articles included in review (with overlap between databases)
Medline (Ovid)	(Aboriginal or 'Torres Strait Islander*' or indigenous) and Australia AND policies or policy or program* or service* or intervention* AND health or wellbeing or well-being AND evaluation	536	54
Scopus	(Aboriginal or 'Torres Strait Islander*' or indigenous) and Australia AND policies or policy or program* or service* or intervention* AND health or wellbeing or well-being AND evaluation	356	60
ATSIhealth	Evaluation	444	47

Tender review

Tender documents usually include a summary of program characteristics, the objectives of the evaluation and the requirements of the evaluator. They are critical to understanding whether strengths and weaknesses in evaluation have arisen in the evaluation process or are a function of the initial requirements. They also outline the obligations and responsibilities of the evaluator. They are also a key mechanism for changing evaluation practice. Two sites were searched for tenders to evaluate programs in health and wellbeing: AusTenders.com and Tenders.net. While AusTenders.com can be searched directly, Tenders.net does not list expired tenders. The timeframe for the review was 2007 to January 2017. A special request was made for an offline search to be conducted and the results sent by email.

In searching for relevant tenders, a broad definition was given to 'health' and 'wellbeing' in order to include evaluation in related fields, such as education, justice and sport. The search resulted in a large number of hits, with more than 12,000 hits returned from a search of the AusTender site. Search results are truncated to include only minimal information, so it is not possible to see the full material of the tender that is being searched. However, with the number of hits returned, it is possible that the words 'Indigenous' and/or 'Aboriginal' are included in a standard phrase in every Australian Government tender, which led to all tenders appearing as search results.

The initial advice from Tenders.net was that a preliminary search showed 1864 matches; however, the final spreadsheet provided had 3441 results. While the representative from Tenders.net advised that the dataset included all public tenders listed on the AusTender site, as well as other sites, the

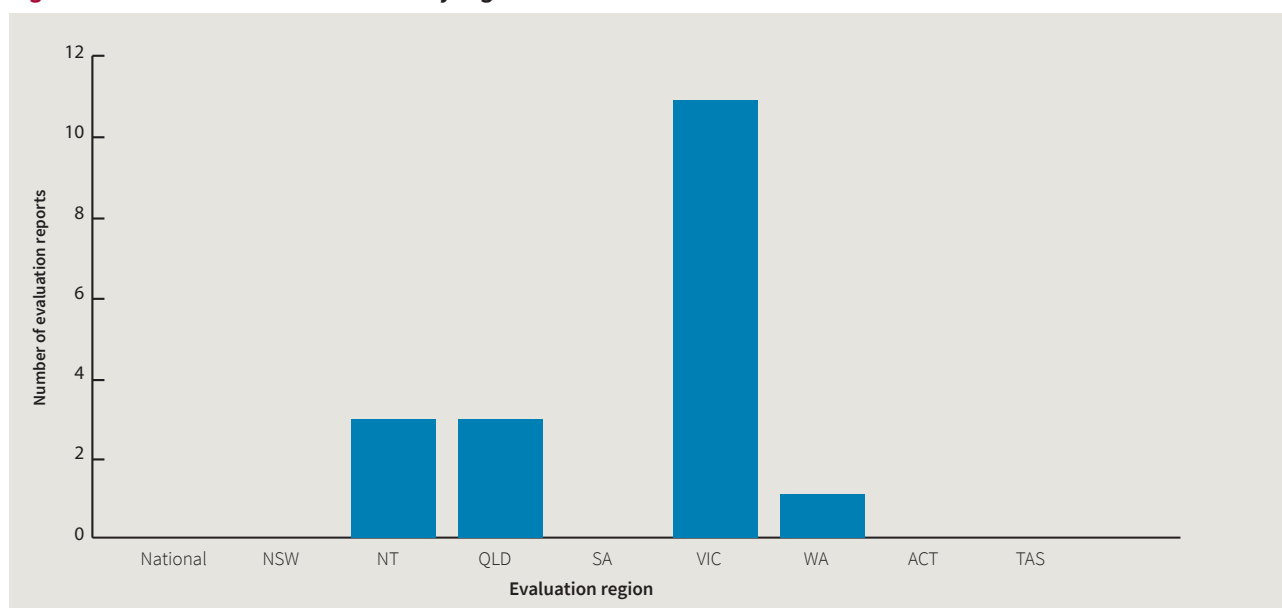
AusTender search returned many results that did not appear in the Tenders.net spreadsheet.

All search results from Tenders.net and AusTender were examined. After elimination of duplications and results that did not fit the criteria, 381 individual records were included. A further nine evaluations were identified from the website of the Australian Indigenous Health/InfoNet, bringing the total records included to 390.

Despite the fact that all tenders are publicly listed initially, none of the tendering organisations nor the sites for publicly listing tenders keep a repository of tender information once it has been let. This poses a significant threat to the transparency and accountability that open tender processes are supposed to foster. It also means it is very difficult to get an accurate historical record of the requirements of evaluators that were specified in terms of delivering benefit to Aboriginal and Torres Strait Islander communities. This in turn means that quality assurance practices to improve the tendering process cannot take place. In order to assess the true availability of tender documents, the team followed up tender records individually. Although it would have been possible to obtain some tender documents from the private archives of individuals or companies, the aim was to assess the public process, so this was not carried out.

In total, we were only able to access 18 tender documents for review. This represents 5 per cent of all tenders identified. All tenders came from state or territory government departments and all were top-down approaches to evaluation developed from within government departments (Figure 3). This small sample size demonstrates a lack of transparency in existing processes and makes it very difficult to adequately comment on current tender practices and how they mesh with community expectations. It also suggests a need to improve the quality of tender processes.

Figure 3: Number of tenders retrieved by region



Evaluation reports

In total, 131 evaluation reports were retrieved for the 390 tenders identified. However, upon review, 31 of these were excluded because they did not pertain to Aboriginal or Torres Strait Islander health (22) or were duplications (9). This left one hundred documents, including 42 national evaluations and 58 evaluations specific to a state or territory (Figure 4).

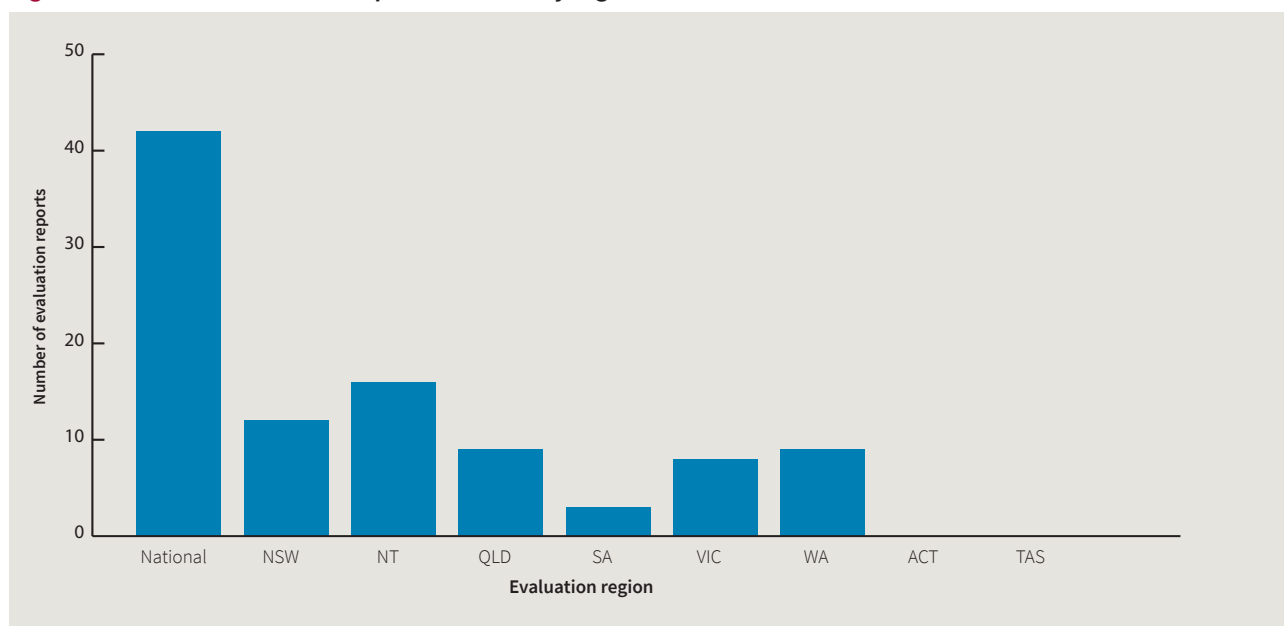
Review process

All evaluation reports were reviewed with regards to both ethics and Aboriginal research principles. These principles were holistic concept of health, partnerships and shared responsibility, cultural respect, engagement, partnership, capacity building, equity, accountability, evidence based and governance. Such principles were informed by *Values and Ethics*:

Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research (NHMRC 2003) and *Keeping Research on Track: A Guide for Aboriginal and Torres Strait Islander Peoples about Health Research Ethics* (NHMRC 2010), as well as state/territory and national Aboriginal health planning documents.

Focusing on the program logics, indicators and overall evaluation framework, the reports were reviewed to determine how well they integrated the principles into the methodologies. The program logics of reports provided an indication of how well principles were integrated into the design of the program/plan/policy to be evaluated. The indicators and frameworks sections of a report provide an indication of how well the principles were integrated and measured as part of the evaluation.

Figure 4: Number of evaluation reports retrieved by region



Workshop

On 8 September 2017 a workshop was held in Melbourne to bring together researchers, evaluation providers, Aboriginal and Torres Strait Islander health service providers, policymakers and Indigenous ethics officers to discuss and provide feedback on all aspects of the evaluation framework. The evaluation framework has been developed to identify the essential elements of evaluation planning and practice and to highlight requirements in undertaking evaluations in Indigenous health in order to increase benefit to Aboriginal and Torres Strait Islander communities. Table 2 lists workshop attendees.

Case studies

Six case studies with attributes of best practice in Aboriginal and Torres Strait Islander evaluation were identified for greater exploration. For each case study, interviews were conducted with evaluators, as well as commissioners, program/policy staff and community members, if available. The focus of the case studies was on highlighting best practice principles that are evident in evaluations around Australia.

The six case studies are evaluations of the following programs/projects/plans:

- Engaging Stakeholders in Identifying Priority Evidence-Practice Gaps and Strategies for Improvement (the ESP Project)—Menzies School of Health Research (national)
- Heart Health cardiac rehabilitation program—Derbarl Yerrigan Health Service (Western Australia)
- Returning Home, Back to Community from Custodial Care pilot program—Muru Marri Indigenous Health Unit, UNSW (national)
- Sentinel Sites Evaluation of the Indigenous Chronic Disease Package 2010–2014—Menzies School of Health Research and The University of Melbourne (national)
- Stronger Communities for Children program—Ipsos and Winangali (Northern Territory)
- Two Gathering Places in the Eastern Metropolitan Region of Melbourne—Onemda Koori Health Unit, The University of Melbourne (Victoria).

Table 2: Workshop attendees

Name	Organisation	State/Territory
Project Team		
Prof. Margaret Kelaher	The University of Melbourne	VIC
Prof. Yin Paradies	Deakin University	VIC
Prof. Shaun Ewen	The University of Melbourne	VIC
Angeline Ferdinand	The University of Melbourne	VIC
Daniel Chamravi	The University of Melbourne	VIC
Joanne Luke	The University of Melbourne	VIC
Attendees		
Kate Kelleher	Kate Kelleher Consulting	NSW
Dr Uncle Mick Adams	Edith Cowan University; Australian Indigenous Health/InfoNet	WA
Samantha Faulkner	NHMRC	ACT
Prof. Judith Dwyer	Flinders University	SA
Scott Avery	First Peoples Disability Network	NSW
Kimina Andersen	Queensland Health	QLD
Dr Clair Scrine	Telethon Kids Institute	WA
Margaret Cashman	Aboriginal Health & Medical Research Council (AH&MRC) of NSW	NSW
Dr Elizabeth Moore	Aboriginal Medical Services Alliance Northern Territory	NT
Mel Shelley	WA Mental Health Commission	WA
Claire Grealy	Urbis	VIC
Trish Malins	Department of Aboriginal Affairs, NSW Government	NSW
Dr Robyn Mildon	Centre for Evidence and Implementation	VIC
Dr Jenny Gordon	Productivity Commission	ACT
Francine Eades	Curtin University, WA Aboriginal Health Ethics Committee	WA
Dr Ruth Nicholls	Department of the Prime Minister and Cabinet	ACT

4. Project findings

This section presents the findings for each of the six key research questions and their contributions to developing an evaluation framework.

Research question 1

What are the key principles that should underpin evaluation of any policy, program or service aiming to improve Aboriginal and Torres Strait Islander health and wellbeing?

Key issues

No coherent framework for the evaluation of policies, programs and services that impact Aboriginal and Torres Strait Islander health and wellbeing currently exists, which leads to a reduction in the quantity, quality, scope and use of available evidence. A coherent framework that guides the evaluation of policies, programs and services to improve the health of Aboriginal and Torres Strait Islander people will ensure that delivering benefit to community is an explicit goal of the conduct and standards of evaluations. This will ensure a greater focus on Aboriginal and Torres Strait Islander engagement in governance, agenda setting and capacity building.

In considering the key principles that should underpin the conduct of evaluations of policy programs and services to improve Aboriginal and Torres Strait Islander health, it is necessary to consider principles underpinning both the conduct of the evaluation itself and the programs to be evaluated.

1. What should evaluations involving policy, programs and services to improve Aboriginal and Torres Strait Islander health and wellbeing address?
2. How should evaluations involving policy, programs and services to improve Aboriginal and Torres Strait Islander health and wellbeing be conducted?

In addressing Research question 1, we focus on the former issue. The second issue is addressed in the following section, which considers Research question 2.

Evaluations are generally designed to be closely linked to the program logic, which is the theory of change associated with the program to be evaluated. If there are also shared principles that apply across programs, an evaluation framework that could be applied across programs could be developed without losing this key concept in evaluation. The federal and state and territory governments commission most of the tenders for evaluation of programs in Aboriginal and Torres Strait Islander health and wellbeing. A review of their health planning documents was conducted to identify key principles underpinning the programs.

Table 3 outlines the key principles included in national, state and territory planning documents in Aboriginal and Torres Strait Islander health and wellbeing. It is apparent that these documents share many key principles. It should be noted that Table 3 was restricted to planning documents, which may have underestimated the extent to which principles are shared. For example, the notion of shared responsibility for Aboriginal and Torres Strait Islander health, 'Making Indigenous health everyone's business', is included in the 2008 *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* (COAG 2008), to which all governments are signatories.

The key principles outlined in the health and wellbeing planning documents include:

- shared responsibility, which is the notion that governments and all health institutions have a responsibility for providing care to Aboriginal and Torres Strait Islander people
- cultural competence, which encompasses cultural respect, cultural safety and cultural security, and which was first defined by Cross et al. (1989) and adapted by the NHMRC as 'a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural situations' (Smullen 2008); among health organisations and health providers, cultural competence is critical to delivering health care that is culturally safe and secure
- engagement with Aboriginal and Torres Strait Islander people, which was included in all documents; some documents specifically recognised the importance of Aboriginal and Torres Strait Islander leadership and the importance of ACCHOs in achieving this
- partnerships with Aboriginal and Torres Strait Islander communities and ACCOs, a principle that was recognised in all planning documents
- capacity building of Aboriginal and Torres Strait Islander staff and community
- equity, which was recognised explicitly in some documents, although arguably it is a key theme in all documents; equity in access to services between Aboriginal and Torres Strait Islander Australians and other Australians is an imperative under Australia's human rights agreement
- accountability of government and funded organisations, which was a key principle in some documents; accountability is not specific to Aboriginal and Torres Strait Islander programs
- evidence-based principles, which encompass the idea that interventions should not only be based on evidence but also generate evidence

- a holistic concept of health, which is the notion that health should encompass all aspects of life; this includes the idea that improving health can have a positive influence on other social factors (e.g. ability to work, school attendance).

Moreover, the need to evaluate programs in Aboriginal and Torres Strait Islander health and wellbeing is a shared value. For example, recently the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023*

identified the need for ‘monitoring and evaluating impacts of program delivery as a means of assessing and building capability to improve health outcomes of Aboriginal and Torres Strait Islander peoples’ (Department of Health 2013).

Overall, Table 3 suggests clear shared values about the principles that should underpin Aboriginal and Torres Strait Islander programs aimed at improving health and wellbeing.

Table 3: Key principles informing government programs to improve Aboriginal and Torres Strait Islander health and wellbeing.

Principle	Government							
	National (Department of Health 2013)	Western Australia (Department of Health 2015)	Victoria (Department of Health 2012)	Northern Territory (Department of Health 2014)	South Australia (Department of Health 2010)	New South Wales (NSW Ministry of Health 2012)	Queensland (Queensland Health 2010)	Australian Capital Territory (Chief Health Officer Australian Capital Territory 2014)
Shared responsibility	✓	✓	✓	-	-	-	-	-
Cultural competence	-	✓	✓	✓	✓	✓	✓	✓
Engagement	✓	✓	✓	✓	✓	✓	✓	✓
Partnership	✓	✓	✓	✓	✓	✓	✓	✓
Capacity building	-	-	✓	✓	-	-	✓	✓
Equity	✓	✓	-	✓	-	-	-	-
Accountability	✓	✓	✓	-	✓	-	-	-
Evidence based	-	-	✓	-	-	-	-	-
Holistic concept of health			✓		✓	✓		✓

Current practice

Tenders and evaluation reports were reviewed to assess the presence of principles for working with Aboriginal and Torres Strait Islander peoples, to characterise their inclusion and to identify indicators. The principles are:

- holistic concept of health
- partnerships and shared responsibility
- cultural respect
- engagement
- capacity building
- equity
- accountability
- evidence based
- governance.

The extent to which these principles are reflected in an evaluation is both a function of the tender requirements and the characteristics of the programs. The integration of principles in a program is evidenced by the program logic and integration of principles in the evaluation, as demonstrated by the indicators. Not all evaluations included formal program logics and indicators (particularly smaller community-based evaluations), so the methodology sections were also scanned to see how programs and evaluations incorporated Aboriginal and Torres Strait Islander research principles. Principles were coded as present if they were identified in any part of the documents reviewed. Principles were coded as absent if they were absent in the documents. This is a key limitation of the approach because the extent to which an absence in reporting translates to an absence in practice is unclear. Furthermore, it is unclear whether the absence of principles in evaluation reports reflects the evaluation or the program. These limitations notwithstanding, the review provides a foundation to improve the incorporation of principles for working with Aboriginal and Torres Strait Islander people in evaluation and/or its reporting.

Holistic concept of health

The National Aboriginal Community Controlled Health Organisation (NACCHO) defines Aboriginal health as:

not just the physical well-being of an individual but... the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community.

It is a whole of life view and includes the cyclical concept of life-death-life. (NACCHO n.d.)

From this perspective, a holistic health approach needs to include the following elements. It needs to:

- recognise physical, social, emotional and cultural health and wellbeing
- recognise individual and community health and wellbeing
- recognise the humanity of Aboriginal and Torres Strait Islander people
- operate across the life-course.

Figure 5 shows the percentage of tenders (17%), evaluation reports (33%) and peer-reviewed literature (26%) reflecting any aspect of holistic health. It is worth noting that how health is interpreted is largely informed by how the program/project/policy to be evaluated positions it.

When considering the abovementioned elements, only three tenders fully embraced a holistic health approach. The first, 'Review of placement prevention and reunification services for Aboriginal children and their families' by the Victorian Department of Health and Human Services, in addition to having a holistic understanding of health, was also trauma-informed and strengths-based. The second, 'Aboriginal social and emotional wellbeing plan evaluation' by the Victorian Department of Justice and Regulation, had a holistic understanding of health in addition to privileging Aboriginal worldviews, as recognised through the inclusion of identity, resilience and culture in health. In this instance, the *Aboriginal Social and Emotional Wellbeing Plan* evaluation (Department of Justice and Regulation 2017) was produced by a working group of government and community organisational representatives, and this in part explains why it strongly aligns with Aboriginal understandings of health. The third example was a tender request for the evaluation of gathering places in Victoria as part of Koolin Balit by the Victorian Department of Health and Human Services. In this instance, health was understood in wellbeing terms and as the health of the whole of the community.

Figure 5: Integration of holistic concept of health into tenders, evaluation reports and peer-reviewed articles

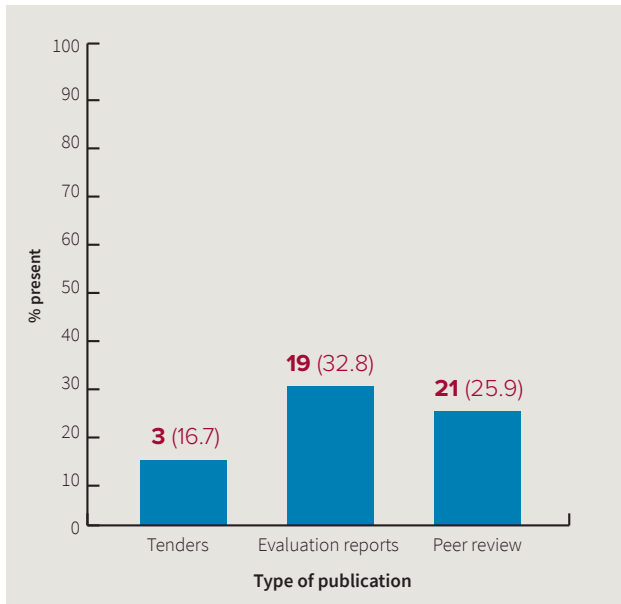
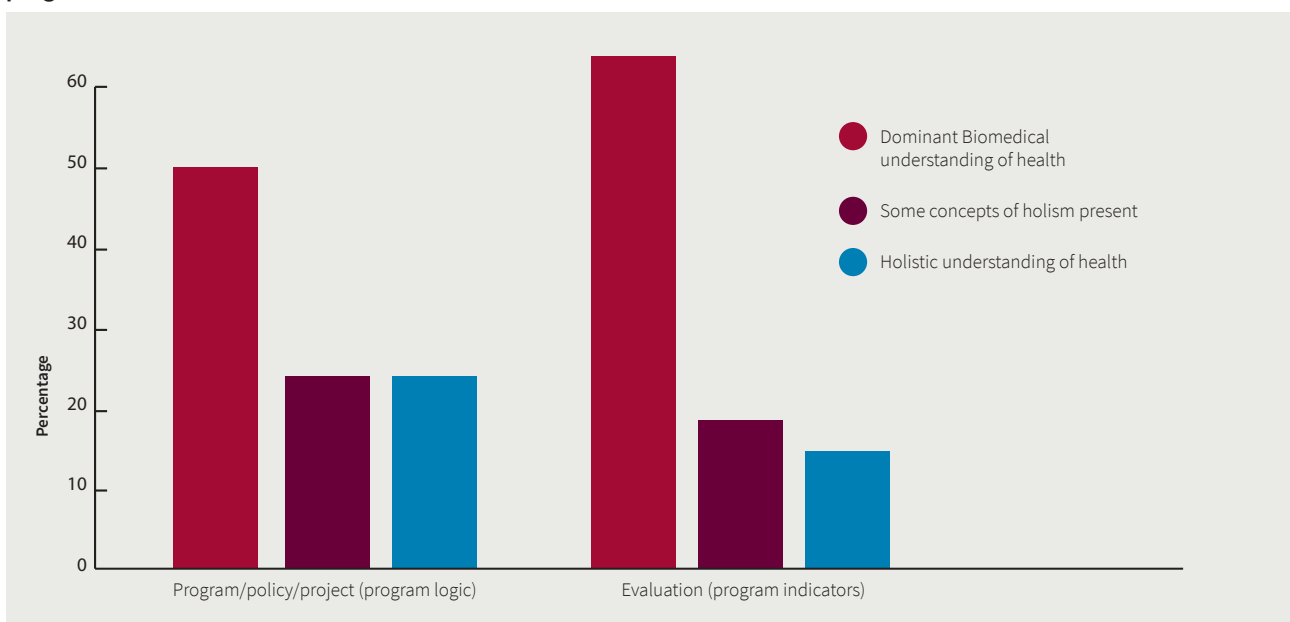


Figure 6 shows the incorporation of a holistic concept of health in evaluation reports and programs. Only a quarter of the programs included a full holistic understanding of health, with half prescribing to a dominant biomedical understanding of health. Even fewer evaluations had indicators that captured the holistic concept of health (14%) or some components of holistic health (19%). It was not uncommon for a program to stipulate that its outcomes were related to holistic health but then have indicators that were largely biomedical.

Figure 6: Integration of holistic concept of health into program and evaluation



The holistic concept of health was better integrated into programs and evaluations that had greater involvement of Aboriginal and Torres Strait Islander people and ACCHOs. It was demonstrated that child health and disability programs were more likely to have components of holistic health. This is likely to reflect social, feminist and rights-based theories underpinning these fields. One program that captures the holistic concept of health is the *Our Men Our Healing: Evaluation Report* (Healing Foundation 2015). This program focused on building strong spirits, strong families, strong culture and strong communities.

The discrepancy between program and evaluation outcome measures reflects the lack of widely accepted and validated measures for indicators of holistic health, and ease and precision in measuring biomedical states of mortality and morbidity. This reflects a real need for measures that accurately capture the holistic concept of health.

Most of the following indicators, which were identified as capturing components of holistic health, came from qualitative evaluations:

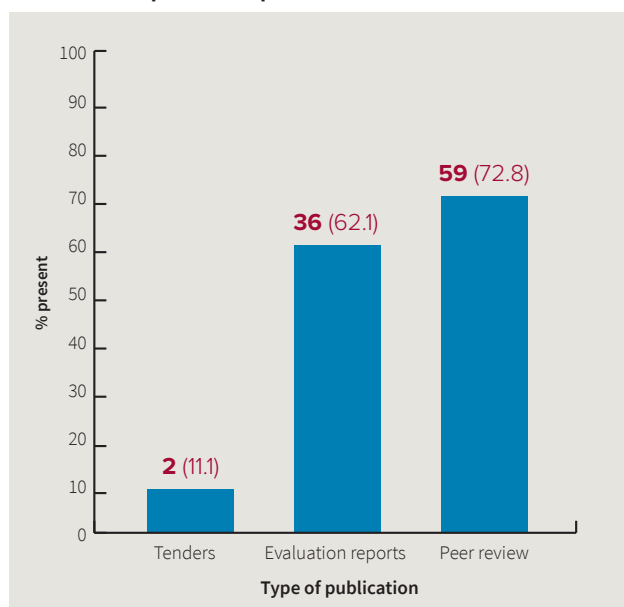
- an increase in the proportion of Aboriginal adults reporting excellent or very good health
- evidence of the program having intergenerational impacts
- the program has strengthened the earlier intervention and prevention response and outcomes for Aboriginal children, young people and families
- evidence of service model and treatment method motivating individuals to change and contributing to enhanced individual, family and community functioning and wellbeing

- improvements to the rights outcomes for Aboriginal people with disability and their families (especially their social, economic and cultural participation and family and community connections).

Partnerships and shared responsibility

Figure 7 shows the percentage of tenders (11%), evaluation reports (62%) and peer-reviewed papers (73%) incorporating partnerships. Partnership was a concept that was commonly integrated in the evaluation reports and peer-reviewed papers; however, it was not clear that the term *partnership* denoted an equal relationship.

Figure 7: Integration of partnership into tenders, evaluation reports and peer-reviewed articles



All the tenders reviewed centred around partnerships between the government department tendering the evaluation and prospective evaluators. Relationships with Aboriginal and Torres Strait Islander people, ACCOs or communities were not central components to any of the tenders. None of the tenders incorporated the Aboriginal and Torres Strait Islander research principles of equal partnerships or shared responsibility. Where partnerships were mentioned, they referred to partnerships between government organisations and evaluators or between different divisions within government departments. There is an obvious power dynamic within evaluations where Aboriginal and Torres Strait Islander people, communities and ACCOs are not treated as equal partners. Aboriginal and Torres Strait Islander people, communities and organisations have no voice in the tender process.

The principles of shared responsibility and partnerships were not present in all the program logics and indicators in evaluation reports and peer-reviewed articles. This is likely due to many of the programs being driven top-down by government or, alternatively, being bottom-up evaluations of local programs by ACCOs. None appeared to be driven by government and community together. Again, it appeared that Aboriginal and Torres Strait Islander people, communities and organisations were not being treated as equal partners. Rather than programs being joint initiatives from the outset, they included outcomes, such as partnerships, that should be established. For example, many have partnership-building as a component of the project and included outcomes such as ‘effective community partnerships established that empower individuals’, ‘improved sustainable systems and funding for partnerships and projects with ACCOs’, and ‘relationships developed, supported and maintained’.

Many outcomes for larger government programs detailed partnerships that were about organisations, including ACCOs, as well as networking and working with external organisations and health providers to provide co-ordinated care. In this instance, partnerships were about organisations achieving predefined program deliverables set out by government policy. Aboriginal and Torres Strait Islander people and organisations were not equal partners.

The following indicators were identified as capturing the principles of shared responsibility and partnership:

number of Memoranda of Understanding (MoUs) or other formal agreements between universal health services and ACCOs

successful and sustainable transition of a program to an ACCO

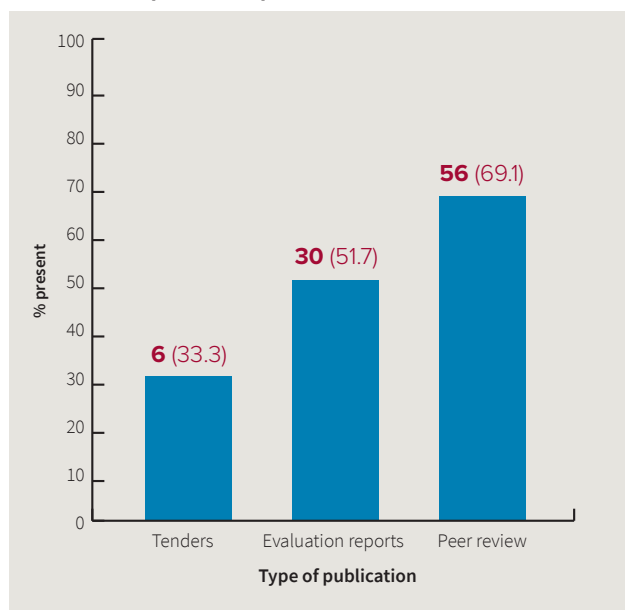
- effective regional governance structures that include community members
- community contribution to planning and design of services
- evidence of a network operating
- self-reported effectiveness of effective partnerships
- self-reported factors that contribute to effective partnerships
- self-reported challenges and strategies to address challenges associated with establishing effective partnerships.

Cultural respect

Figure 8 shows the integration of cultural respect into tenders (33%), evaluation reports (52%) and peer-reviewed literature (69%).

The principle of cultural respect was not widely integrated into tenders. Only a third of the programs integrated a component of cultural respect. This largely consisted of potential evaluators having demonstrated experience conducting research with Aboriginal and Torres Strait Islander people in a culturally competent way. An example includes the 'Aboriginal health evaluation—improving cultural responsiveness of hospitals', by the Victorian Department of Health and Human Services, which had a criterion requesting that potential reviewers 'demonstrate culturally appropriate research methods'.

Figure 8: Integration of cultural respect into tenders, evaluation reports and peer-reviewed articles



Cultural difference between Aboriginal and Torres Strait Islander peoples and the dominant culture was recognised in many programs and their evaluations. Cultural respect was usually framed as non-Aboriginal people and organisations becoming sensitive, culturally secure, culturally appropriate, culturally inclusive, culturally respectful, culturally safe or culturally responsive to Aboriginal and Torres Strait Islander peoples' cultural differences.

An example that sought to change the culture of hospitals, *Aboriginal Identification in Hospitals Quality Improvement Program* (Wilson et al. 2017) by NSW Health, included cultural respect as a program outcome, including mechanisms for cultural leadership and advice at the executive level; increased representation of Aboriginal culture and people in hospital emergency departments (EDs); improved physical environment in ED waiting areas, including ensuring a more culturally welcoming environment; improved formal acknowledgment of traditional owners; improved cultural competency of ED staff; and increased knowledge of Aboriginal services among social work department staff, all of which were evaluated.

The following indicators were identified as capturing some cultural respect principles:

- cultural knowledge and practices are incorporated into the operations of the service
- Indigenous culture is addressed in the training
- self-assessment of cultural awareness competency
- the extent to which the program is able to meet different community needs in a culturally responsive way
- new or revised administrative and clinical orientation, staff training and materials regarding Aboriginal identification and cultural awareness
- self-reported cultural security of early childhood services
- early childhood workers with cultural competence training
- the extent to which the program has contributed to improved community safety and perceptions of community safety.

Engagement

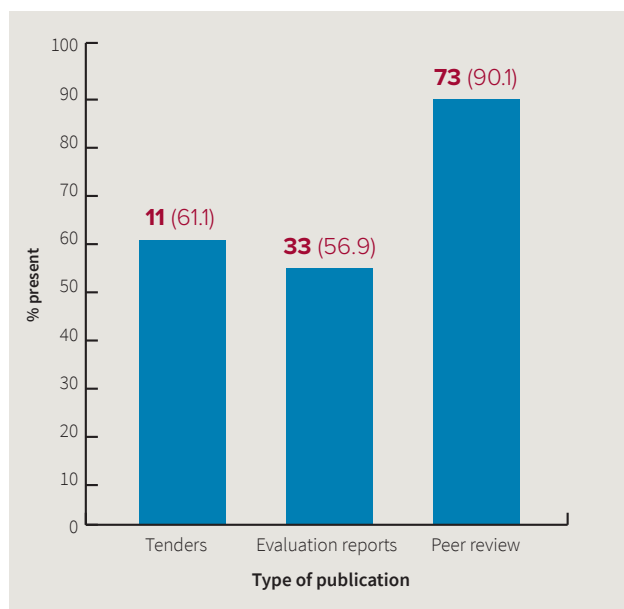
Figure 9 shows the integration of engagement into tenders (61%), evaluation reports (56%) and peer-reviewed literature (90%).

The levels of engagement requested in tenders differed greatly. They ranged from employment of Aboriginal and Torres Strait Islander people, listing key organisations that must be engaged, requirements for Aboriginal and Torres Strait Islander patients to be engaged as research participants, and requirements for Aboriginal and Torres Strait Islander people/organisations to be engaged on reference groups to vague comments stipulating that 'consultation' and 'collaboration' is required with Aboriginal and Torres Strait Islander communities as part of program success. One in three tenders did not mention engagement with Aboriginal and Torres Strait Islander people, ACCOs or organisations.

The tenders also differed with regards to who should be engaged (people, communities or ACCOs). The Victorian Department of Health and Human Services tender 'Aboriginal health evaluation—improving cultural responsiveness of hospitals' required an engagement strategy for individual Aboriginal people. Another tender by the Victorian Department of Health and Human Services, 'Evaluation of Aboriginal health case management and care coordination models', similarly required an engagement strategy for engaging community-controlled organisations. In considering Aboriginal research principles, engagement with communities and ACCOs, as opposed to individuals, would likely be more appropriate given the collective nature of decision making in Aboriginal communities and the diversity of experience of Aboriginal people.

One tender by the NSW Ministry of Health, 'Evaluation of Aboriginal maternal & infant health service', requested that prospective evaluators 'include the names of three (3) Aboriginal referees who can be contacted to discuss your organisation's experience working with Aboriginal people and communities'. This focus on individuals is problematic because individuals do not speak for all Aboriginal people or communities. It would be more appropriate to require a reference from an organisation.

Figure 9: Integration of engagement into tenders, evaluation reports and peer-reviewed articles



The levels of engagement differed between programs and included Aboriginal and Torres Strait Islander engagement through employment and consultation, endorsement of a pre-designed program, participation as research participants, representation on committees or reference groups, or involvement in the co-design, planning and/or implementation of a program. The programs also differed with regards to who

should be engaged (people, communities or ACCOs). Across the programs and program evaluations there was no underlying consistency or informed rationale regarding who to engage.

A good example of engagement with Aboriginal and Torres Strait Islander people and organisations was the *Evaluation of Indigenous Justice Programs Project B: Offender Support and Reintegration* by the Attorney-General's Department (CIRCA & Anne Markiewicz and Associates 2014). This program was developed and designed by Aboriginal staff, involved consultations with staff of ACCOs, and linked in with Aboriginal and Torres Strait Islander Elders and respected community members.

The following indicators were identified as capturing the principles of engagement:

- the number of community leaders who endorse a program
- the number of community leaders who believe a program is appropriate
- the extent to which the program influences inclusion, engagement and decision making at local and regional levels
- Aboriginal staff leadership/ownership of continuous quality improvement processes
- the number of collaborative organisations and participants
- the effectiveness of mechanisms for community and board input/feedback
- the number of meetings seeking community input
- programs on the agenda of routine ACCO board meetings
- community member involvement in the set-up and/or running of the panel service
- self-reported satisfaction with the community engagement process
- self-reported factors that contribute to positive community engagement
- self-reported challenges and strategies to address challenges
- documented and self-reported status of community engagement processes
- self-reported challenges and strategies for addressing challenges
- the number and type of mechanisms for engagement of universal health services with Aboriginal community members.

Capacity building

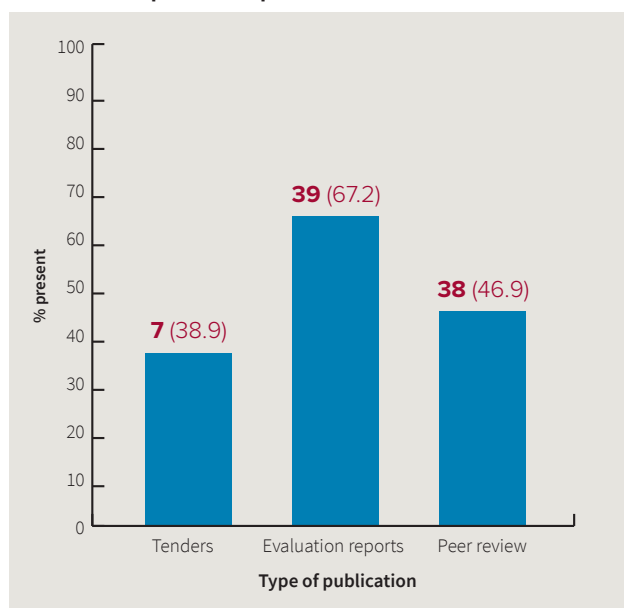
Figure 10 shows the integration of capacity building into tenders (39%), evaluation reports (67%) and peer-reviewed literature (47%).

Seven tenders mentioned capacity building at either the individual or organisational level. Four tenders from the Victorian Department of Health and Human Services included a blanket statement that, as part of the project plan, the successful evaluator would be required to plan 'how the evaluation will contribute to building evaluation capacity of health services, including Aboriginal staff where possible'. However, this was not included as a tenderer criterion.

A good example of capacity building built into a tender is in the 'Evaluation and development of Aboriginal community engagement and partnership framework' tender by the Victorian Department of Human Services, which has the criteria, 'The tenderer either has Aboriginal consultants employed within its organisation or will be partnering with an external Aboriginal consultant/s'. This selection criterion is heavily weighted, indicating the importance of capacity building as part of the evaluation process.

Two tenders, one from the Northern Territory Department of Education, 'Evaluation of Indigenous education strategy', and the other from the Department of Business, 'Evaluation of employment & economic development policies', include in their conditions of tender, 'Where specified in the Annexure, the Tenderer will, if awarded the Contract, maintain an Indigenous employment rate which will be no less than thirty per cent (30%) of the total workforce engaged in the delivery of the Supplies'. This is aimed at building capacity of individual Aboriginal and Torres Strait Islander people.

Figure 10: Integration of capacity building into tenders, evaluation reports and peer-reviewed articles



As demonstrated by the evaluation reports, many of the programs were designed with capacity building built into a program at either the individual, community or organisational level. At the individual level, this largely related to building the capacity of individuals through training and employment to participate in the wider economy, or capacity to self-manage a condition. At the community level, this was about strengthening the community and building resilience in communities so that they can improve their own outcomes. At the organisational level, most programs were concerned with building the capacity of mainstream health services through employment and cultural competency training. ACCO capacity building was largely around governance and improving accountability.

The following indicators were identified as capturing the principles of capacity building:

- an increase in numbers of Aboriginal staff employed in mainstream health services
- workforce recruitment and retention rates in ACCOs
- the number of regional ACCOs that are accredited
- the number of operational/active Aboriginal Health Workers
- the number of Aboriginal Health Worker trainees
- the number of additional health professionals recruited and operational
- the number of Aboriginal staff in the health workforce
- the effectiveness of community capacity building efforts in underpinning a longer-term enhancement of community control
- involvement of community members in program operations
- the effectiveness/appropriateness of the training
- an increase in the impact/s of grants and traineeships provided to Aboriginal people
- new or improved mechanisms for cultural leadership and advice at the executive level
- new/modified sustainable systems to increase and support the Aboriginal workforce in an ED
- new or revised administrative and clinical orientation, staff training and materials regarding Aboriginal identification and cultural awareness
- self-reported factors contributing to increased supply of workers

- the number of professional development hours on Aboriginal and Torres Strait Islander education and cultural and linguistic competence training undertaken by principals and teacher
- the distribution of scholarships over the life of the program
- case studies that demonstrate links between improved systems and patient outcomes.

Equity

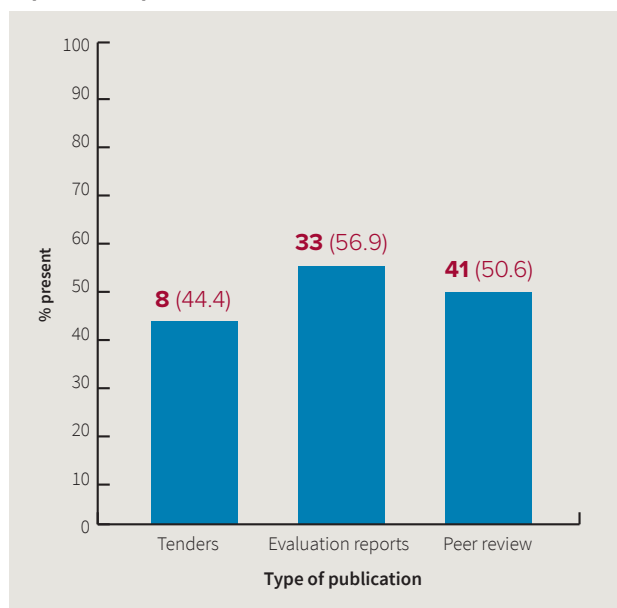
Figure 11 shows the integration of equity into tenders (44%), evaluation reports (57%) and peer-reviewed literature (51%).

The principle of equity underpins most of the tenders and evaluations. This is not surprising as the period of review—2007 to 2016—coincides with a period of heavy government investment in reducing health disparities and overcoming disadvantage through initiatives such as Closing the Gap. Many of the Victorian evaluations sit under the Koolin Balit health strategy (2012–22) (Department of Health 2012), a framework that has equity-based objectives around improving Aboriginal health outcomes relative to non-Aboriginal people.

Equity is largely framed around reducing inequities and increasing access to services and information and rights to equal treatment (including legal, human and civil rights). It is worth mentioning the Aboriginal Social and Emotional Wellbeing Plan evaluation by the Victorian Department of Justice and Regulation (2017); rather than measuring how the plan responds to equity, the evaluation recognises Aboriginal differences such as strength of culture, which demonstrates an understanding of equity as recognising Aboriginal difference. The right to self-determine is enshrined in the United Nations Declaration on the Rights of Indigenous Peoples, which Australia supports and has promised to be guided by (Howse 2011; United Nations 2008).

Two tenders were for evaluation of programs involving non-Aboriginal populations, as well as Aboriginal populations. These were Victorian tenders for the ‘Evaluation of regional immunisation initiatives’ by the Department of Health (2017a) and the ‘Evaluation of Cradle to Kinder & Aboriginal Cradle to Kinder programs’ by the Department of Health and Human Services. In both instances, Aboriginal people were framed as an at-risk or deficit population and the overarching program objectives were to overcome this disadvantage.

Figure 11: Integration of equity into tenders, evaluation reports and peer-reviewed articles



In terms of integrating the principle of equity into the evaluation, two tenders from the Northern Territory sought to redress equity through employment. This was achieved via a clause stipulating that 30 per cent of the evaluation team had to be Aboriginal.

Similarly, in evaluation reports, the principle of equity underpinned most of the programs being evaluated.

The following indicators were identified as capturing equity, although we are mindful that many are Eurocentric in nature:

- the number of people who accessed the health service for any reason
- evidence on whether the work of Wellbeing Centres is contributing to achievement of the Closing the Gap targets, particularly those that relate to the life expectancy gap and mortality
- attendance rates of Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander students
- enrolment to population ratio of Aboriginal and Torres Strait Islander Australians compared to other Australians
- the proportion of Aboriginal and Torres Strait Islander students at or above the national minimum standard in reading, writing and numeracy
- changes in spending patterns, food and alcohol consumption, school attendance and harassment
- evidence of increased hospital recording of Aboriginal identification

- reduction in after-hours primary care-type ED presentations by Aboriginal people
- rates of discharge of Aboriginal people from hospital against medical advice
- increase in proportion of Aboriginal children and families who participate in maternal and child health key age and stage visits
- an increase in the proportion of Aboriginal children immunised at key age milestones
- an increase in the uptake of programs that aim to improve positive lifestyle behaviour during pregnancy to help provide an optimum environment for the baby to grow
- an increase in access to mental health services earlier for young Aboriginal people
- an increase in Aboriginal people accessing mainstream community health services, aged care assessment services, and Home and Community Care services
- an increase in Aboriginal people accessing eye health services
- an increase in access to services addressing chronic conditions.

Accountability

Accountability here refers to the accountability of evaluators to Aboriginal and Torres Strait Islander communities. Figure 12 shows the integration of accountability into tenders (78%), evaluation reports (12%) and peer-reviewed literature (23%).

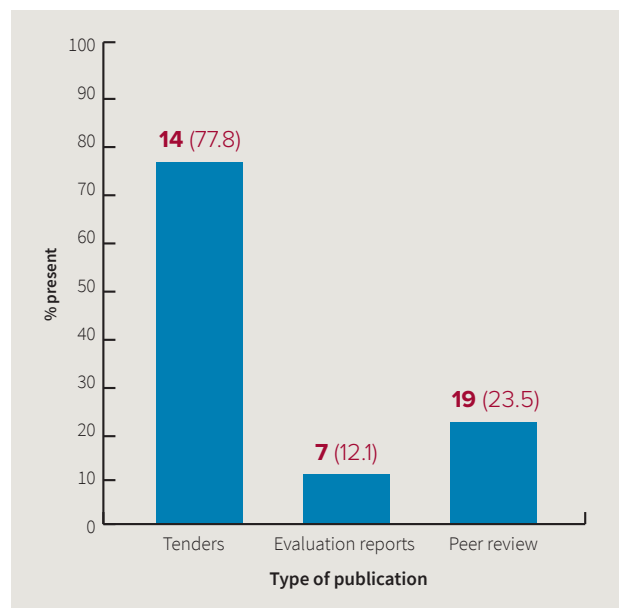
Fourteen tenders specified that prospective evaluators should demonstrate accountability in terms of experience, knowledge or commitment. Experience requirements included evaluating Aboriginal programs, conducting Aboriginal research, experience working with Aboriginal communities and organisations, and experience engaging and consulting with Aboriginal organisations. Knowledge of Aboriginal communities, the Aboriginal health sector, and Aboriginal policy and program frameworks was also desirable.

This type of accountability, demonstrating that evaluators have the capacity to undertake the evaluation, was one of the few Aboriginal research principles that was integrated widely into the tenderer criteria.

Good examples of accountability included the tender ‘Aboriginal health evaluation—improving cultural responsiveness of hospitals’ by the Victorian Department of Health and Human Services, which included a criterion, ‘The key personnel who will be undertaking the project can demonstrate experience of conducting research and/or evaluation with Victorian Aboriginal communities, including the use of culturally appropriate research.’

Another good example, in the ‘Evaluation of Indigenous education strategy’ tender by the Northern Territory Department of Education, required the prospective evaluator to ‘Demonstrate experience in the ethical conduct of research/evaluation in schools and Indigenous communities.’

Figure 12: Integration of accountability into tenders, evaluation reports and peer-reviewed articles



However, accountability was a principle that was less well integrated into or measured in the program evaluations. It was not always clear who needed to be ‘accountable’—government, community, the program or the evaluation.

An example of accountability incorporated into a program’s guiding principles was contained in the *Lungurra Ngoora Community Care Service Evaluation Report* (Yarmintali Consultancy 2010:8), which defined accountability as ‘A service or program [that] ought to develop processes and [strategies] to show transparency of operations and accountability. Services should be accountable to the community and funding agencies and should be based on joint ongoing planning.’

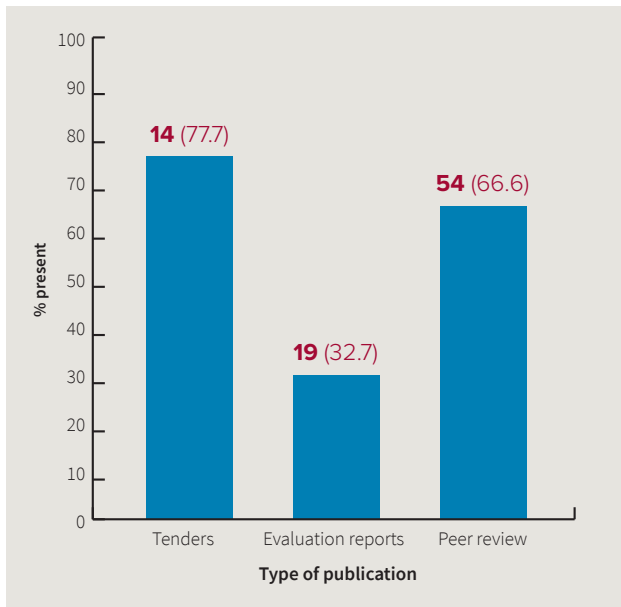
The following indicator was identified as capturing accountability:

- the extent to which the government agencies involved have met their commitments to the Aboriginal Justice Agreement.

Evidence-based approach

Figure 13 shows the integration of an evidence-based approach to evaluation in tenders (78%), evaluation reports (33%) and peer-reviewed literature (67%).

Figure 13: Integration of an evidence-based approach into tenders, evaluation reports and peer-reviewed articles



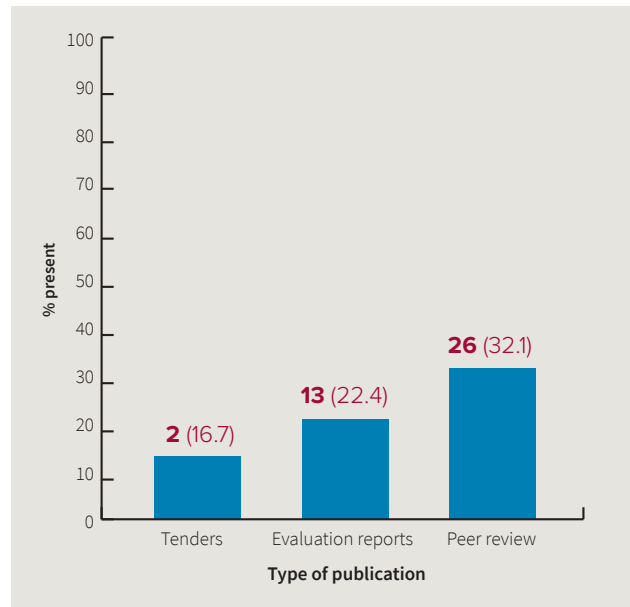
Fourteen tenders specified that prospective evaluators were required to use an evidence-based approach. This includes evaluators using frameworks, program logics, methodologies and processes that are valid and effective. An example includes the tender for the ‘Evaluation of Aboriginal health workforce development’ by the Victorian Department of Health and Human Services, which specified that ‘The proposed methodology demonstrates an understanding of the Specification requirements and represents a valid, innovative and effective approach to the delivery of Specification requirements’. In addition, this tender also required rigor through use of the purpose-built Koolin Balit logic model and indicators.

Use of available evidence was a principle that was not well integrated into the programs and evaluations. A few evaluation reports included general comments within the program logics, such as the need for the program to build or deliver evidence-based strategies or apply best practice protocols.

Governance (including data governance)

Figure 14 shows the integration of governance including data governance into tenders (17%), evaluation reports (22.4%) and peer-reviewed literature (32.1%). Tender reviews revealed that many of the evaluations had existing governance groups overseeing the projects. Membership of these advisory or reference groups largely comprised government employees who provided advice around project methodology, as well as cultural and technical advice. Only three tenders (16.7%) specified that membership on a reference group should include representatives from the Aboriginal community or an ACCO (Figure 14).

Figure 14: Integration of Aboriginal governance into tenders, evaluation reports and peer-reviewed articles



A good example of governance is the ‘Evaluation of Aboriginal maternal & infant health service’ tender by the NSW Ministry of Health, which had a specialist Evaluation Advisory Committee that included Aboriginal organisations (AH&MRC of NSW and ACCOs) and specialist Aboriginal people (Aboriginal Health Workers), as well as government representatives. The main role of this group was advisory. However, it also monitored progress, ensured that cultural protocols and procedures were included in design and implementation of the evaluation, and oversaw the use, interpretation and management of data. These are ways that Aboriginal and Torres Strait Islander people, communities and ACCOs can have a voice in the evaluation process.

In several tenders, it was not clear if governance groups had designated positions for Aboriginal and Torres Strait Islander people, communities or ACCOs. For example, the ‘Evaluation of employment & economic development policies’ tender by the Northern Territory Department of Business was overseen by a project steering committee comprising government representatives from five different departments, one of which was the Office for Aboriginal Affairs; however, this is not to say that this person was Aboriginal and/or Torres Strait Islander. Four Victorian projects had to go to a Department of Health and Human Services Aboriginal Health Evidence & Evaluation Working Group review to ensure they were technically and culturally appropriate. Again, this group comprised government representatives who were considered ‘research, data and evaluation experts’, but it was not mentioned if membership included Aboriginal and/or Torres Strait Islander people. Without Aboriginal and Torres Strait Islander membership, it is questionable whether any governance group could advise

on cultural appropriateness. In addition, groups of non-Aboriginal people are not well placed to know what is in the best interests of Aboriginal and Torres Strait Islander people and communities, particularly when they are socially, culturally and geographically distanced from them.

For tenders, where intellectual property (IP) was discussed, it was only discussed in terms of agreements between the government department commissioning the tender and prospective evaluators. The management of IP belonging to Aboriginal and Torres Strait Islander individuals, communities and ACCOs was not discussed. While it is possible that there are other contractual arrangements covering Aboriginal and Torres Strait Islander IP associated with an evaluation, this would be unusual.

Most government departments had standard contracts that legally outlined IP as part of the terms and conditions of tender. These largely protected government interests. In standard contracts, IP was mostly retained with commissioners, although in a few cases the prospective evaluator retained IP for the evaluation. However, where IP sat with prospective evaluators, there were clauses to allow government departments full use of property. An example is from the contract for the 'Evaluation of regional immunisation initiatives' tender by the Victorian Department of Health (2017a): 'the Department accepts, a non-exclusive, irrevocable, world-wide, perpetual, payment-free licence to use, reproduce, publish, communicate to the public, adapt, modify, exploit and sublicense [sic] that Intellectual Property to the extent necessary to enable the Department to enjoy the full benefit of the Project, the Services and this Agreement.'

One example, 'Consultancy—alcohol management regime', from the Northern Territory Department of Justice, states that all IP belongs with the Northern Territory Government: 'Any material produced will remain the property of the Northern Territory Government. This includes any interim and final reports, data sheets from any surveys or interviews conducted and the indicators developed as part of the evaluation.' This means Aboriginal and Torres Strait Islander individuals, communities and organisations do not have a legal voice in how data are interpreted or used unless this is granted in a further contract.

In the evaluation reports, many of the programs reported governance groups overseeing projects across the program, including its evaluation. These largely provided advice around project methodology, as well as cultural and technical advice. One project with examples of good governance is the *Chronic Care Service Enhancements Program Evaluation* by the Health Behaviour Research Group at the University of Newcastle (Health Behaviour Research Group 2016). Section 2.3 details the governance arrangements. Good governance principles include collaborative partnerships with ACCOs, and governance structures include place as well as data governance protocols. This program also integrated the following principles:

- efficiency/effectiveness as the governance structures of the program
- collaboration
- update ACCOs with program and evaluation progress
- ACCOs feedback and dissemination of findings
- formal consent
- ACCOs guidance
- data governance protocols
- MoU and tailored interventions to allow for Aboriginal and Torres Strait Islander community control within the evaluation.

Data governance was mentioned in a 2009 report by Urbis, *Evaluation of the Healthy for Life Program* (Urbis 2009), in which the authors highlight that lack of control over how data are used is a real issue for ACCOs.

The following indicators were identified as capturing governance:

- efficiency/effectiveness of governance structures of the program
- support for leadership and governance in Indigenous communities
- level of satisfaction with current governance arrangements among stakeholders
- extent to which current governance arrangements have helped or hindered the rollout, monitoring and administration of the program
- involvement of community members in the operation of the panel
- recruitment processes for panel members
- self-reported effectiveness of established management and governance structure
- self-reported challenges, and strategies to address challenges, associated with effective management and governance structures.

Key findings

Review of the tender documents and the evaluation reports revealed that principles for working with Aboriginal and Torres Strait Islander people are not widely or consistently integrated into programs, tender documents or program evaluations. However, there were some positive exemplars of principle-based evaluations, as outlined in Box 1. Overall, the degree to which Aboriginal and Torres Strait Islander principles were integrated into a tender or evaluation ultimately depended on how well they were integrated into the program being evaluated. This suggests a real need for Aboriginal and Torres Strait Islander principles to be included at the program planning stage so they can be carried through to the evaluation.

In part, the incomplete integration of Aboriginal and Torres Strait Islander principles in evaluations reflects a focus on the *Aboriginal and Torres Strait Islander Health Performance Framework* (AIHW 2017), with lesser attention paid to other relevant government frameworks. Where a program was led or developed with input by ACCOs, Aboriginal research principles were better integrated into the program and hence the evaluation. For example, evaluations by the Victorian Aboriginal Community Controlled Health Service (VACCHO) had strong capacity building within the program logics (program), as well as indicators (evaluation). This finding suggests opportunities to learn from ACCOs in developing evaluation indicators for these tools. This trend was also evident for programs developed and tendered through Aboriginal and Torres Strait Islander units within government departments.

The equity and evidence-based principles were most widely integrated into tender documents and evaluation reports. This likely reflects a national policy environment dominated by campaigns to close the gap and overcome Indigenous disadvantage. The other key principles—holistic concept of health, partnerships and shared responsibility, cultural respect, engagement, capacity building, accountability and governance—were less integrated into evaluations.

Box 1: Principle-based evaluation

Principle-based practice in evaluation is a function of being guided by a set of values, rather than strict adherence to prescriptive rules. As such, principles must be contextualised and interpreted in accordance with the situation in order to be relevant and appropriate. In the context of Aboriginal and Torres Strait Islander health program evaluation, principle-based practice can enhance evaluation effectiveness as it reflects Aboriginal and Torres Strait Islander communities' conceptualisations of health, priorities and viewpoints. In the frameworks of three evaluations, Aboriginal and Torres Strait Islander research principles featured strongly:

- *Lungurra Ngoora Community Care Service Evaluation Report*, Yarmintali Consultancy (2010)
- *Chronic Care Service Enhancements Program Evaluation*, Health Behaviour Research Group (2016)
- *Returning Home, Back to Community from Custodial Care: Learnings from the First Year Pilot Project Evaluation of Three Sites around Australia*, Muru Marri (Haswell et al. 2014).

The frameworks for these three evaluations call on many of the principles within the NHMRC guidelines (Greene et al. 2006) but also offer further principles that could strengthen evaluations, including self-determination, community control, and privileging of Aboriginal and Torres Strait Islander epistemologies and methodologies. Principles reflected in the program logics and evaluation indicators in these projects include a holistic understanding of health, cultural leadership, strong relationships, spirit, workforce development and addressing determinants of health. In the case of the evaluation of the Chronic Care Service Enhancements Program, the evaluation framework was developed in consultation with ACCOs in New South Wales and had a strong community governance approach, which included Aboriginal community control in decision making and data governance.

The review of evaluation reports revealed that Aboriginal and Torres Strait Islander research principles were often included to some degree as outcomes within a program's program logic. For example, many programs listed wellbeing or engagement as outcomes in their program logic. However, very few programs had indicators that fully measured these outcomes. This probably reflects a lack of widely accepted or validated indicators to measure Aboriginal and Torres Strait Islander principles. This suggests a real need to identify indicators that capture constructs such as holism, cultural respect, and Aboriginal and Torres Strait Islander engagement

The workshop to discuss the evaluation framework raised important issues around the principles. There were concerns that some concepts, such as partnership, were used so frequently in situations where they did not actually apply that they lost their meaning. This was well supported by the review, which found very little evidence of equal partnerships. There were also concerns that a focus on Aboriginal and Torres Strait Islander capacity building often failed to take into account existing community strengths and expertise, particularly around understanding community priorities and knowledge of programs and the history of local implementation. Although some of the principles do focus on building capacity among mainstream organisations, this tends to focus on program implementers/service deliverers rather than commissioners. There needs to be recognition that mainstream capacity development needs to occur across all roles in the program planning and evaluation cycle.

Finally, the difficulty in obtaining tender documents and evaluation reports suggests that little quality assurance occurs around ensuring that tender processes and evaluations address the commissioner's principles. At the workshop, concerns were expressed both by Aboriginal and Torres Strait Islander and government participants about the extent to which evaluation reports met their needs and expectations. Commissioners have clear leverage to influence the conduct of evaluations through both the tender process and the management of evaluations. There is also evidence that this leverage is often applied to ensure that evaluations are of high quality, at least from a commissioner perspective. Despite this, evaluation methodology is often suboptimal because the imperatives around completion tend to be driven by policy cycles rather than rigour or community benefit. Lack of a central repository for tender documents and evaluation reports means that there is limited opportunity for past practice, particularly for successful processes, to inform new tender processes. This loss of institutional knowledge is particularly significant given high turnover in government positions. Box 2 outlines positive initiatives to improve transparency in evaluation reporting.

Box 2: Improving transparency, increasing utility

An underlying tenet of evaluation practice is knowledge transfer and the uptake of evaluation findings in future decision making. Where evaluation is undertaken and subsequently fails to be made available, this represents a waste of resources. Moreover, transparency in evaluation is an ethical requirement, as Aboriginal and Torres Strait Islander communities have the right to know about the effects of programs that affect them, and a right to the findings from evaluations they have participated in.

As part of its Indigenous Advancement Strategy evaluation framework, the Department of the Prime Minister and Cabinet has made a commitment to improve transparency in evaluation (PM&C 2017). This recognises that increased transparency is necessary for the continuous improvement of evaluation practice and ensures that evaluation is able to contribute appropriately to the policy development cycle. Two aspects of transparency have been considered: assessing progress of the framework and supporting the use of evaluations.

The first aspect represents a commitment to review evaluations and publish these reviews. The review of evaluations will help to assess the extent to which the framework has achieved its aims in accordance with best practice principles. The second aspect is concerned with the use of the evidence provided by evaluation in the development of future policies and programs. The ethical practice of ensuring that communities are provided with evaluation findings will also be enhanced. The framework therefore lays out a commitment to make all evaluation reports or summaries publicly available to the extent possible while complying with ethical confidentiality concerns or commercial in confidence requirements. Additional avenues for making evaluation findings accessible and available for use in informing practice and policy will also be explored.

Key findings are summarised below.

- A review of publicly advertised evaluation tenders over the past ten years found that only 5 per cent of tender documents and 33 per cent of evaluation reports were publicly available. This lack of transparency precludes comprehensive review of the evidence. It also suggests that levels of evaluation will be underestimated if numbers of reports are used.
- All Australian governments have agreed principles for working with Aboriginal and Torres Strait Islander people and these would be expected to be included in tender documents specifying evaluations.
- Tenders, evaluation reports and peer-reviewed literature did not consistently address government-agreed principles for working with Aboriginal and Torres Strait Islander people.
- The equity and evidence-based principles were most widely integrated into tender documents and evaluation reports. This likely reflects a national policy environment that is dominated by campaigns to close the gap and overcome Indigenous disadvantage.
- Principles of holistic concept of health, partnerships and shared responsibility, cultural respect, engagement, capacity building, accountability and governance were less well integrated into evaluations. This was particularly true of holistic health, which rarely reflected the NACCHO definition. It was also true of partnership, which, although present to some extent, rarely reflected equal partnerships between Aboriginal and Torres Strait Islander people and other organisations.
- Evaluations led by ACCHOs were more likely to fully integrate principles for working with Aboriginal and Torres Strait Islander people, suggesting a leadership role in improving evaluation.

Research question 2

What would be the key elements in a systems-based framework to guide evaluations of policy, programs and services whose goals are to improve Aboriginal and Torres Strait Islander health and wellbeing?

Key issues

Initiatives to address Aboriginal and Torres Strait Islander health take place within complex settings. The success or failure of these programs depends on factors both within and outside the health sector, such as fluctuations in policy priorities, high

levels of disadvantage and under-resourced organisations (Muir & Dean 2017). Aboriginal and Torres Strait Islander health programs must, among other considerations, take into account the resources that the community brings to bear on the issue; relationships between various organisations and government entities; social determinants of health as experienced by the community; community politics; and existing health policy and practice (Durey et al. 2012; DiGiacomo et al. 2007; Bailie et al. 2010; Thompson, Gifford & Thorpe 2000; Dawson et al. 2013). As such, Aboriginal and Torres Strait Islander health can be conceptualised using a systems-based approach, which is concerned 'with the interrelationships between parts and their relationships to a functioning whole, often understood within the context of an even greater whole' (Trochim et al. 2006). In examining such programs, evaluations in Aboriginal and Torres Strait Islander health must also be alert to this complex interplay of factors. Moreover, the translation of evaluation findings into evidence that is then used as the basis for further policy and program development requires the involvement of actors from various sectors and located at different levels of government (Brown et al. 2015; Vujcich et al. 2016).

Without the translation of evaluation findings into practice, communities do not benefit from participation in the evaluation. This is not only a waste of resources but a violation of key ethical principles in Aboriginal and Torres Strait Islander health research (NHMRC 2003, 2010). One key barrier to the effective utilisation of evidence is the disconnect that exists between the generation of knowledge and those who have the capacity to influence policy and practice. Rectifying this distance necessitates engagement with key stakeholders from the beginning of the evaluation process (Laycock et al. 2016). This helps to ensure that relevant stakeholders are aware of the evaluation and are able to guide it, if necessary, so that the evidence that is generated by the evaluation is relevant and useable.

However, before ensuring that the evaluation is usable for policymakers, it must first be designed to serve the needs of the relevant Aboriginal and Torres Strait Islander communities. Bainbridge et al. (2015), in writing about Aboriginal and Torres Strait Islander health research, highlight that deciding what 'benefit' entails depends on the viewpoints of those deciding the outcomes that are desirable, with Western and Indigenous perspectives providing very different ideas about what counts as a tangible benefit. Adhering to the principle of research benefitting Aboriginal and Torres Strait Islander communities entails, for example, a research design that reflects the conceptualisations of the community regarding their own health and that addresses those priorities that have been identified by the community. This necessitates centring Aboriginal and Torres Strait Islander leadership from the initial stages of both the evaluation and the program.

In order for this to happen, there needs to be capacity from within Aboriginal and Torres Strait Islander communities to either conduct health program evaluations on their own behalf or engage with evaluators, program funders and implementers to ensure the appropriateness of programs. This perspective is reflected in the ethical research principle to build capacity in Aboriginal and Torres Strait Islander communities (NHMRC 2003). At the same time, however, there is a need to reflect on what is meant by capacity. The term capacity building, has been criticised because it highlights deficits in Aboriginal and Torres Strait Islander communities rather than acknowledging community strengths. There is also a need to improve the capacity of evaluators and government entities to engage appropriately and work collaboratively with Aboriginal and Torres Strait Islander communities (Tsey et al. 2012).

Logically, in order to translate evaluation results into action, the results of evaluations, as well as their associated recommendations, must be easily accessible after the conclusion of the research. The ability to review evaluation findings is also important for transparency and accountability because it is a key way to keep track of current and past practice in Aboriginal and Torres Strait Islander health. Moreover, affected Aboriginal and Torres Strait Islander communities have the right to know what the impact of past and current programs has been, and should be able to access information that concerns them (Young et al. 2016).

Current practice

Positive initiatives that are currently underway to improve the evaluation of programs addressing the health and wellbeing of Aboriginal and Torres Strait Islander people may well increase the benefits of evaluation to these communities (PM&C 2017; Department of Health 2017b). However, there has been little progress in the five years since concerns were raised in the 2012 Productivity Commission roundtable (Productivity Commission 2013). In considering how to progress, this project has summarised these concerns into four main areas:

- translation from evaluation into action
- Aboriginal and Torres Strait Islander leadership and partnership
- building the evidence base
- evaluation and ethics.

Translation from evaluation into action

The most constant criticism from Aboriginal and Torres Strait Islander communities about evaluation and other types of research is that the findings are not translated into action and thus not of benefit to communities. For example, many of the issues examined in the Royal Commission into the Protection and Detention of Children in the Northern Territory arose from unaddressed recommendations in the 2007 *Little Children are Sacred* report (Wild & Anderson 2007), which examined sexual abuse among Aboriginal children, and the 1991 report of the Royal Commission on Aboriginal Deaths in Custody (Johnston 1991). There are examples where there has been a clear link between the evaluation cycles and the development of policy and programs. For example, a 2011 Senate report, *The Effectiveness of Special Arrangements for the Supply of Pharmaceutical Benefits Scheme (PBS) Medicines to Remote Area Aboriginal Health Services*, outlines the link between evaluation and program responses in this program since 1997 (Community Affairs References Senate Committee 2011). However, the articulation between evaluation and policy and programs development is often unclear. The current project highlights difficulties in accessing tender documents (5% available) and evaluation reports (33%). The difficulty in accessing this information in part explains confusion about what has been evaluated and whether the findings have been used for policy and program development. Greater transparency in both is crucial to move evaluation forward.

Recommendations from evaluation may not be implemented for various reasons. However, Aboriginal and Torres Strait Islander communities often do not receive feedback about evaluation findings or information about responses to evaluation. Lack of feedback to Aboriginal and Torres Strait Islander communities is not only problematic from the point of view of transparency and accountability, but is inconsistent with the fundamental tenets of ethical guidelines for working with Aboriginal and Torres Strait Islander people (NHMRC 2003). As outlined in Box 3, this was a source of frustration for commissioners and community alike.

Box 3: ‘Nobody works on an evaluation for fun’

Failure to release evaluation reports was a frustration not only for evaluators, Aboriginal and Torres Strait Islander people, and program implementers but also commissioners. The value of releasing evaluation reports was recognised by all parties. Although decisions not to release evaluation reports are typically made by commissioning agencies, these decisions often reflect political rather than program imperatives. Exceptions were cases where there were concerns about the quality of the evaluation; however, this is likely to make up a small proportion of the reports that are not released. Commissioners, like the other parties involved, expend time and resources in ensuring that evaluations are of appropriate quality and meet their needs. Overall, developing clear commitments around transparency would ensure that the resources invested in evaluation are both clear to the public and of benefit. Positive change is reflected in moves by the Department of the Prime Minister and Cabinet (PM&C 2017) to release all evaluations in either report or summary form (as outlined in Box 2).

There is a strong focus on ethics in Aboriginal and Torres Strait Islander research because of a recognition that Aboriginal and Torres Strait Islander communities have not benefited from the research they have participated in. The governance, consultation, capacity building and feedback processes associated with ethical research practice in Aboriginal and Torres Strait Islander projects aim to ensure community benefit. The key documents overseeing this are *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research* (NHMRC 2003) and *Keeping Research on Track: A Guide for Aboriginal and Torres Strait Islander Peoples about Health Research Ethics* (NHMRC 2010). While the guidelines purport to include evaluation, they are primarily tailored to investigator-driven research. The guidelines deal with the relationship between the researchers and researched, the researched in this case including both participating individuals and communities, and assume that the researcher will work with communities in consultation, program planning, evaluation of the program and dissemination. The difficulty in applying this to evaluation is that various parties are involved in program evaluation: these include the commissioners, program implementers, evaluators and recipients for the program. The relationship between these parties means that ethical obligations should be shared in ways that they rarely are. For example, evaluators are usually only involved once a program

has been designed, which means that consultation associated with the establishment of projects and governance associated with their implementation have already been established. Additionally, intellectual property rights, dissemination and action following the evaluation are often the responsibility of the commissioner. This means that key components of evaluation processes are not handled according to ethical guidelines.

Aboriginal and Torres Strait Islander leadership and partnership

The current project focuses on government-initiated publicly advertised evaluation processes. It was difficult to find evidence from the tender documents or the evaluation reports of leadership and/or partnerships with Aboriginal and Torres Strait Islander communities and/or organisations. This may reflect the lack of such processes or a lack of reporting on them. To clarify this issue, we examined the use of ethical guidelines in evaluation. Ethical guidelines make clear stipulations around the need to work with Aboriginal and Torres Strait Islander communities and have clear governance, feedback and data-sharing processes, as well as capacity building (NHMRC 2003). The ethical requirement to have Aboriginal and Torres Strait Islander leadership in evaluation is also underpinned by the United Nations Declaration on the Rights of Indigenous Peoples, which obligates governments to consult with indigenous peoples in relation to matters that concern them, as well as to uphold the rights of indigenous peoples to self-determination (United Nations 2008).

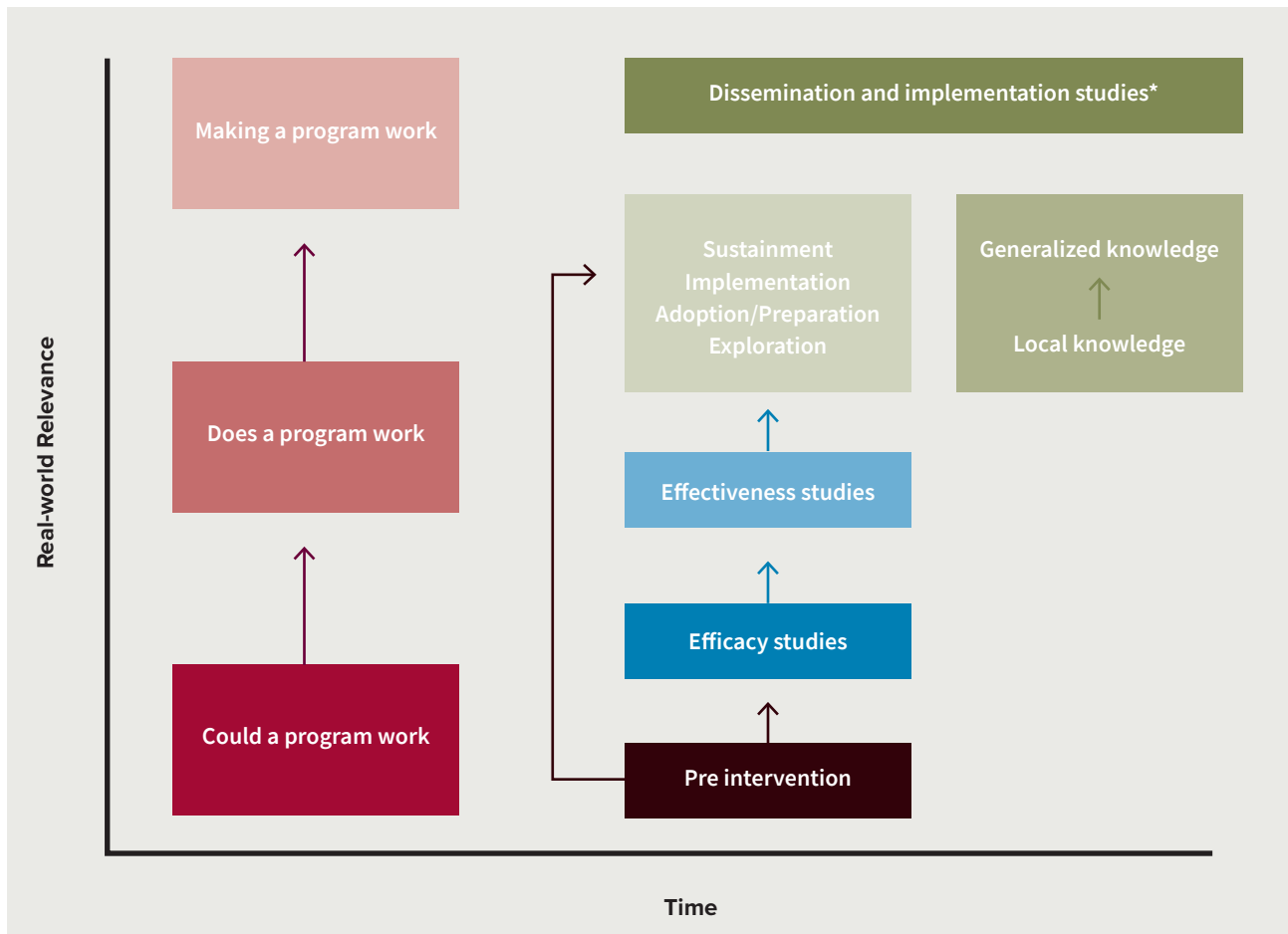
All health planning documents referred to partnerships with Aboriginal and Torres Strait Islander communities as a key principle. However, the term *partnership* in Indigenous contexts has been heavily criticised as being vague and encompassing everything from superficial consultation to shared decision-making processes. In examining the ethics of engagement and partnership in Canadian indigenous research, Brunger and Wall (2016) found that uncritical partnerships may actually undermine community autonomy, cause harm to individuals or deepen tensions within the community. There is therefore a need to move beyond superficial partnerships to include Aboriginal and Torres Strait Islander communities as equal players in developing health programs and evaluations or enabling them to take the lead in these processes. This has led to a call for a recommitment from the government to reform the Closing the Gap strategy with stronger Aboriginal and Torres Strait Islander leadership and more resources directed towards strategies led by Aboriginal and Torres Strait Islander communities (National Congress of Australia's First Peoples 2016). This initiative is supported by a growing body of evidence suggesting that the inclusion of Aboriginal and Torres Strait Islander people in governance leads to improved processes and better outcomes (Kelaher et al. 2014).

Building the evidence base

Lack of access to information about evaluations and their findings is a significant barrier to building the evidence base in Aboriginal and Torres Strait Islander health. It also prevents evidence-based priority setting and quality assurance processes around evaluation. Although repositories have been established to bring evaluation information together (e.g. King et al. 2013; AIHW & Australian Institute of Family Studies 2017), these resources are only able to provide access to information that is publicly available. Providing open access to tender and evaluation information would considerably add to their utility. It is important that any review of evaluations follows conventional standards and includes multiple search strategies, including the peer-reviewed literature. Failure to do so may mean that higher quality evaluations are missed. Even if comprehensive search strategies are used, the number of currently available evaluation reports will significantly underestimate evaluation activity.

Building the evidence base through successive program and evaluation cycles is iterative. Evaluation encompasses a range of methodologies for a range of purposes from formative to summative. In contemporary evaluation theory, no methodology is considered as the gold standard; rather, it is crucial that whatever approach is used is fit for purpose (Brown et al. 2017; Victora, Habicht & Bryce 2004). The appropriateness of the method depends on the stage of maturity of the program being evaluated. Figure 15 outlines the relationship between the type of study and the maturity of the program. There are evaluative methods that are appropriate for each of these stages. Small-scale qualitative evaluations are perfectly appropriate for pilot programs, particularly to support proof of concept and to identify adverse effects before large-scale rollout. In fact, it could be wasteful to launch a large-scale Randomised Controlled Trial (RCT) without such data. RCT or quasi-experimental methods are considered the preferred methods for efficacy studies. However, threats to external

Figure 15: Link between program development and methodology



*Dissemination and implementation studies include systematic evaluation, monitoring and adaption
Source: Brown et al. 2017

validity, particularly with RCT, limit their use in effectiveness studies (Victoria, Habicht & Bryce 2004). It should also be noted that RCTs and quasi-experimental methods are only ethical in situations where there is equipoise. For example, the PBS Closing the Gap co-payment measure was rolled out nationally, preventing quasi-experimental or RCT approaches. However, there had been extensive evaluations of medicines initiatives in Aboriginal and Torres Strait Islander health and the success of the Quality Use of Medicines Maximised (QUMAX) pilot, and rigorous evaluation of medicines listed on the PBS (Community Affairs References Senate Committee 2011). The use of RCT or quasi-experimental methods for evaluation would have served to deprive Aboriginal and Torres Strait Islander people of a program likely to benefit them. To understand where evaluation practice needs to improve, it is important to be able to trace the trajectory of programs. There has been criticism that there is an over-reliance on qualitative methodology in the evaluation of Aboriginal and Torres Strait Islander health programs (Hudson 2017). This may be the case, but the predominance of qualitative methods may also reflect a failure to develop programs to the point where other methods are appropriate. It is important to develop data sets that disentangle these issues. It is also critical that where evidence from evaluations does exist, it is used to understand how well policy and programs are performing. Box 4 outlines some key issues associated with this.

A final issue is with transparency, particularly in relation to evaluation and data concerning communities. Ideally in evaluation, data collected from Aboriginal and Torres Strait Islander communities are returned to these communities, often in the form of reports and data books. Actual data are often not provided because of restrictions on data sharing and/or lack of capacity for data storage and management. Such data are provided to communities so that they can use the data for their own purposes and MoUs often include provision for ongoing support. However, even in cases where best practice is followed—that is, data collection is done in partnership with a community organisation with evaluation capacity and there is a detailed MoU, as well as regular reporting and clear handover processes—reports and data can still be lost because the data are held by individual staff at the organisations involved. Accordingly, staff turnover at any of the organisations involved may create barriers to data access or mean that knowledge of available data resources is lost. Ideally, capacity would be established within communities. However, it may be good to link this with other data repositories.

There have been ongoing calls to improve data repositories around evaluation. There are currently excellent resources, such as the Australian Indigenous HealthInfoNet, but their utility is limited by lack of publicly available information. Expanding the role of the Australian Indigenous HealthInfoNet would significantly advance the evidence base around evaluation. It would also be worth considering the development of a directory of current evaluations to enable sharing of information and the development of evaluation networks (FaCSIA 2010).

Evaluation and ethics

The most important finding from this review of government tenders is that there is no consistency regarding ethics requirements for evaluations involving Aboriginal and Torres Strait Islander populations. Nor is there an ethic to give Aboriginal communities a voice in the evaluation through meaningful engagement or control of the evaluation.

Figure 16 shows where ethics clearance was specified in tender documents and obtained in evaluations. Five tender documents (28%) did not mention ethics. The 13 tenders (72%) that referred to ethics did so to varying degrees. Of these, five required definite ethics clearance and stated specifically which Human Research Ethics Committee (HREC) must clear the evaluation or stated that an NHMRC-approved HREC must clear the evaluation. Another tender mentioned that ethics clearance might be required, depending on methodology, while the remaining seven indicated that ethics clearance was desirable but not mandatory—they included requests for potential evaluators to develop ‘a risk management plan including ethics’ or to detail the ‘approach that will be taken to obtain approval’. Only the ‘Evaluation of Cradle to Kinder & Aboriginal Cradle to Kinder programs’ tender by the Victorian Department of Health and Human Services mentioned that the evaluation was to be guided by the NHMRC *Values and Ethics guidelines* (NHMRC 2003). Similarly, the New South Wales ‘Ministry of Health evaluation of Aboriginal Maternal & Infant Health Service’ tender document specified that the State-specific *AH&MRC Guidelines for Research into Aboriginal Health: Key Principles* (AH&MRC Ethics Committee 2016) should guide the evaluation.

Box 4: Putting the program into performance

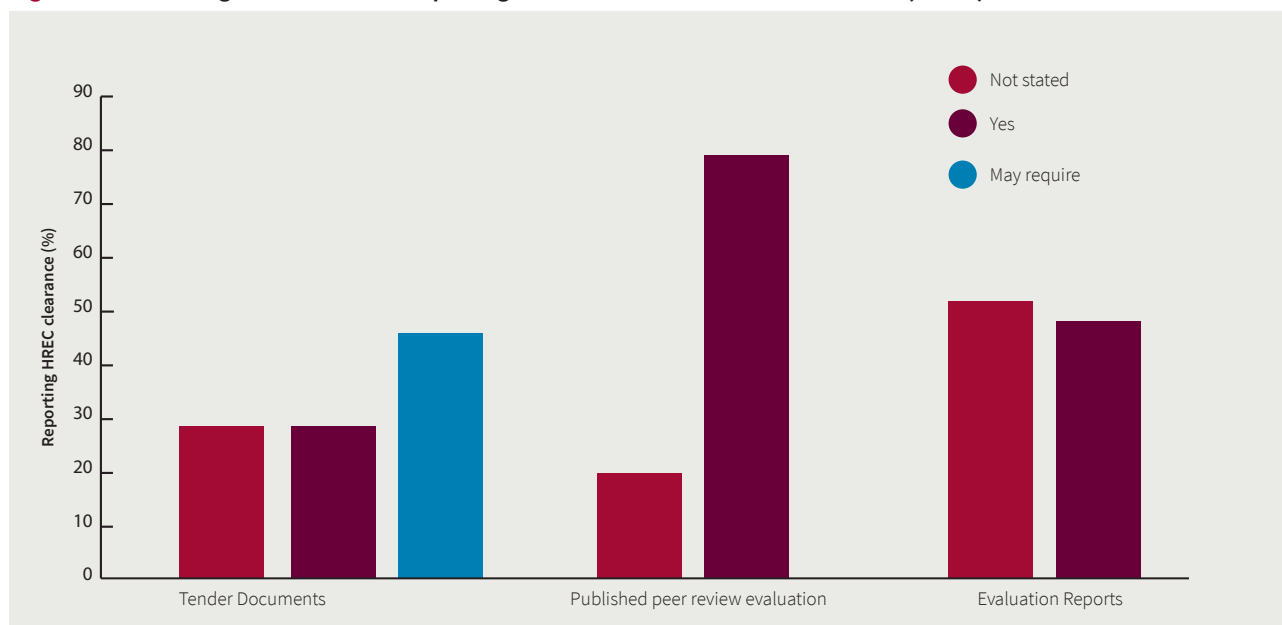
There have been major reports on improvements in Aboriginal and Torres Strait Islander health and other parameters associated with Closing the Gap. The reports focus on shifts in indicators at a national level (SCRGSP 2014, 2016). In the absence of any change, such reports tend to conclude that there is 'little or no evidence about what works' (Russell 2015). Reviewing changes in indicators over time can at best show that something is working but it can never really tell 'what works'. Identifying 'what works' requires linking programmatic activity to indicator change.

This was recognised by the Productivity Commission in relation to its 2014 *Overcoming Indigenous Disadvantage* report (SCRGSP 2014, 2016). Evaluations were included in the 2016 report but only 34 evaluations were found (SCRGSP 2016). The evaluations were obtained by searching the Closing the Gap Clearinghouse (AIHW & Australian Institute of Family Studies 2017), which appears to underestimate the number of evaluations in health compared to other sources. It is, however, beyond the scope of this project to comprehensively assess this. An additional review of evaluations was completed by Hudson (2017). The search strategy for this review was not conventionally reported. It appears that it was based on a previous search that examined program funding in Aboriginal and Torres Strait Islander health at the organisational level rather than in terms of its original source. This review appears incomplete. For example, neither review includes the Sentinel Sites Evaluation (SSE) of the Indigenous Chronic Disease Program, which

represents several millions of dollars in evaluation investment of a program commitment of around \$260 million per annum. The SSE is documented in publicly available reports and in the peer-reviewed literature and should have been identified either through search strategies or validation processes (Bailie et al. 2013). A third review of evaluation design and methods was published in 2017 (Lokuge et al. 2017). The methodology for this review is conventionally reported but the search included only one database and only included peer-reviewed literature. The included studies are not reported for this review, although it seems likely that it is complete with reference to the search parameters. However, exclusive focus on peer-reviewed literature will mean that much of the work done in evaluation is not captured. This will particularly be true of evaluations completed by ACCHOs and by commercial evaluators where publication in the peer-reviewed literature is not a dissemination priority.

Overall, there is increasing recognition that evaluation is critical to understanding whether programs are achieving their aims. Any review of evaluation in Aboriginal and Torres Strait Islander health and wellbeing, including this project, will be limited by a lack of transparency in this area. Accordingly, it is important that reviews use multiple sources, validate their approaches and identify potential biases. There is substantial investment of time and resources in evaluation and it is critical that this is used in the most effective way to benefit Aboriginal and Torres Strait Islander people. Developing appropriate infrastructure to enable critical examination of the evidence base is crucial to capitalising on this investment.

Figure 16: Percentage of evaluations reporting Human Research Ethics Committee (HREC) clearance



Similarly, the review of evaluation reports revealed no consistent requirements for ethics clearance in evaluations. Just under half (48%) of the evaluation reports specified that ethics approval was obtained. Ethics approval was much more likely to be reported in the peer-reviewed literature (80%). The reported rates may be an underestimation of ethics approval, as some evaluations may have obtained ethics clearance and not reported it. Evaluations where ethics approval was reported were generally for larger government projects, as well as those conducted by universities. This may reflect institutional ethical processes, with government and academia intending to minimise institutional liabilities. Evaluations where ethics approval was not reported were often reviews of policy, plans or smaller community-level programs. Such evaluations may be considered low risk. However, if Aboriginal and Torres Strait Islander people or organisations are involved as evaluation participants or if data are constructed about Aboriginal people, then such projects should consider obtaining ethics approval.

Evaluations by ACCOs, such as VACCHO’s 2012 *An Evaluation of a Series of Harm Reduction and Alcohol and Drug Awareness Activities within Victorian Aboriginal Communities* (VACCHO 2015) and the *Evaluation of the Bila Muuji Smoking Cessation Project* (Stephenson 2012), did not mention ethics. This likely reflects the lack of capacity of ACCOs to access HREC committees and complete ethics approval processes. Despite many of the ACCO-driven evaluations not mentioning ethics, they were largely better at integrating Aboriginal research principles. This inconsistency in evaluators seeking ethics approval draws attention to the fact that there are no clear and consistent requirements when doing evaluations with Aboriginal and Torres Strait Islander populations.

Moving forward

Overall, there was a sense that moving towards self-determination for Aboriginal and Torres Strait Islander peoples was an important direction for evaluation practice but that there was a considerable gap between that goal and current practice. There was a sense that Aboriginal and Torres Strait Islander people should be involved in evaluation:

- design
- implementation
- data analysis and interpretation
- reporting
- dissemination
- future data use.

This would help ensure that evaluation data and reporting were meaningful to Aboriginal and Torres Strait Islander people. It was also felt that this engagement should start in the program design phases.

Evaluations follow programs

If a program has been designed with little engagement or consideration of the communities’ priorities, this can create problems that follow through to the evaluation. Evaluators are often limited to evaluating a program as it exists. Accordingly, if a program does not align with community priorities, it is difficult to design and evaluate.

There is a considerable need to develop new approaches to evaluation that consider the overall contribution to health equity of evaluation in Aboriginal and Torres Strait Islander health and wellbeing. Benatar and Singer (2000) have proposed ‘a new, proactive research ethics... concerned with reducing inequities in global health and achieving justice in health research and health care’ (pp 825). This requires shifting the focus of ethics from issues that arise within the researcher–participant relationship to ensuring that benefits to health and research capacity reach communities, particularly those that are disadvantaged and marginalised. For example, while researchers are ethically bound to feed information back to communities, the same ethical obligations do not apply to government. This is reflected in the IP clauses in many standard evaluation contracts, where IP is held by the commissioner. There are often provisions for the evaluators to use the data later but there are no provisions for community to use the data. Neither is there necessarily a requirement for commissioners to release evaluation reports to the communities in which the data were collected, nor a requirement to outline a response to the evaluation. In a research context, failure to share reports and respond to them would be seen as inconsistent with ethical guidelines; however, such practices are common in evaluation. It is important that ethical obligations associated with the collection of data are seen as constant, regardless of who has carriage for that part of the evaluation process.

These new ethical frameworks to ensure that research and evaluation deliver ‘health justice’ identify specific obligations for evaluators, commissioners and program evaluators (Ruger 2009). Parties are assigned obligations because the functions they typically assume make them particularly capable of fulfilling the obligations. This means that, for example, the content of the obligation to carry out research capacity strengthening varies according to the roles actors typically perform. Evaluators generally work at the project level and are, therefore, responsible for capacity building in the project context and when building collaborations with Aboriginal and Torres Strait Islander communities. Commissioners of evaluations determine the evaluations that are funded and who is considered appropriately qualified to conduct them, and, through their policies and programs, enact guidelines for the evaluations they fund. Commissioners have a responsibility to fund capacity strengthening as part of evaluations, as well as funding initiatives that specifically support capacity development (Pratt & Hyder 2015). Commissioners are also responsible for ensuring that evaluations are translated into policy and programs (Pratt & Hyder 2015; Pratt & Loff 2014).

Table 4 shows an adaptation of these ethical concepts to the evaluation of Aboriginal and Torres Strait Islander health and wellbeing programs and the tasks associated with conducting an evaluation. The table reflects feedback from the workshop that suggested that it was important to map the trajectory between current practices and where we would like to move in the future. The middle column, ‘Where we are moving to’, reflects what is achievable in the short term. The trajectory is towards both self-determination for Aboriginal and Torres Strait Islander people and greater transparency and accountability for commissioners. Current practice in evaluation varies greatly. High-quality evaluations currently demonstrate at least some of the aspects of practice in the ‘Where we would like to be’ column. However, there were no examples of completed (or planned) evaluations that address all of them. Promising new models such as the Opportunity Choice Healing Responsibility Empowerment (OCHRE) evaluation outlined in Box 5 may more fully address these responsibilities. The area where the greatest development is required is around knowledge translation. The review highlighted problems in the availability of evaluation documents. There are promising initiatives to commit to greater transparency. For example, the Department of the Prime Minister and Cabinet (PM&C 2017) has committed to releasing evaluation reports unless there are ethical reasons not to. This initiative is outlined in Box 2. Although this is a significant step forward, it falls short of ensuring that evaluations translate into action, which is the primary concern of Aboriginal and Torres Strait Islander communities and which is where practice should ultimately land. A significant advance would be to provide a response to evaluations so that it is clear to Aboriginal and Torres Strait Islander communities that information they have provided has informed decision making and program development. This would be consistent with the enhanced performance framework under the *Public Governance, Performance and Accountability Act 2013* (Cth), which highlights the need for greater accountability through evaluation (Department of Finance 2017).

Box 5: OCHRE evaluation: Policy co-production and evaluation co-design

OCHRE is the community-focused plan for Aboriginal affairs in New South Wales. OCHRE aims to transform the New South Wales Government's relationship with Aboriginal communities, thereby supporting Aboriginal influence and participation in social, economic and cultural life. OCHRE was the result of an extended consultation process between government and communities that began in 2011. The consultation process was based on the principle of policy co-production in response to Aboriginal community concerns about the limited improvement in the lives of Aboriginal people in New South Wales. The evaluation of OCHRE has been included as an emerging example of how government is attempting to build stronger Aboriginal governance and partnership across an evaluation.

The Social Policy Research Centre at the University of New South Wales was engaged to undertake the evaluation. The evaluation team includes two Aboriginal researchers and the Chief Investigator has led previous Aboriginal policy-related projects. The evaluation will deliver information progressively from implementation to impacts over a ten-year period. Importantly, the evaluation was built in to OCHRE from the start. The evaluation approach, as currently conceived, has transformed in response to local history and context, and the knowledge systems and expectations of local communities. Maintaining an evaluation anchored in community aspirations and ways of doing business has proceeded through strong engagement, obtaining Aboriginal community consent, and co-designing the methodology and data collection.

The evaluation takes the form of a continuing conversation in more than 30 communities. The areas of priority identified through the process, seen as key levers to achieving social and economic advancement, are education and economic agency; nurturing Aboriginal language, culture and identity; supporting local leadership to increase Aboriginal participation in decision making; and increased accountability for expenditure and decision making that impact on Aboriginal communities.

Although positive in many ways, the co-design process has exposed tension when attempting to integrate Aboriginal-informed approaches into evaluation. Notable among these are:

- different beliefs about the rigour of evaluation methods
- different expectations about the pace at which the evaluation should proceed
- different beliefs about the time commitment required by Aboriginal people and communities
- questions about the cultural authority of an individual to speak on behalf of a community
- differences about the importance of detailing the study procedure and other documents before the evaluation can commence
- different views on what constitutes success and how to measure this, including pre-specification of outcome measures
- different views about the place of baseline data
- differences in responsibilities, interests, values, practices and influence.

These tensions need to be reconciled because different approaches lead to different priorities, different focuses and ultimately different findings. Resolving these tensions is a work in progress. Aboriginal Affairs NSW is working to address the relative power of the groups involved, building and supporting a culturally capable practice environment where the very real differences to knowledge systems are recognised and respected, and building maturity in practice.

The co-design and decolonisation approaches of the OCHRE evaluation are coherent with the program's underlying philosophy and privilege Aboriginal leadership, priorities and knowledge. These approaches have led to the use of methodological strategies that also reflect strong community engagement. However, the evaluation highlights some of the difficulties in working across different knowledge systems and ways of working, which necessitates ongoing negotiation.

Table 4: Adaptation of the research for a health justice framework to the evaluation of Aboriginal and Torres Strait Islander programs in health and wellbeing—moving towards the future

Developing programs to improve Aboriginal and Torres Strait Islander health	
Where we are coming from	Where we are moving to
<ul style="list-style-type: none"> • Current program development practice is largely top-down, overseen by commissioners with unbalanced and intermittent involvement by Aboriginal and Torres Strait Islander communities. • There are no engagement requirements, with commissioners not mandated to engage or partner with Aboriginal and Torres Strait Islander communities and other stakeholders, such as service providers. • The health needs and priorities of Aboriginal and Torres Strait Islander communities can be overlooked as there is no requisite requiring commissioners to respond to existing or emerging health needs as articulated by or with community. • There is no consistent approach to which evidence informs program design. Evidence-informed approaches are constrained by the under-utilisation of government and community data, limited access to reports on past program effectiveness and previous evaluations, and a tendency for some programs to be ad hoc and reactive responses (e.g. the Northern Territory National Emergency Response). • Opportunity and capacity for Aboriginal and Torres Strait Islander communities to participate in priority setting and program development processes is inconsistent across current practice. • Commissioners do not widely support and enhance existing skills and knowledge of Aboriginal and Torres Strait Islander people and communities. 	<ul style="list-style-type: none"> • Engagement of Aboriginal and Torres Strait Islander communities and other stakeholders such as service providers. • Consider/conduct/share review of epidemiological data/ community assessment and other relevant data. • Review data on program effectiveness and previous evaluations. • Program responds to existing or emerging health needs articulated with community. • Program logic developed and reflects shared agenda. • Establish processes to ensure program’s accountability to Aboriginal and Torres Strait Islander community. • Normative expectations that program and partnerships address priority areas for improving health equity identified by community. • Strengthen the capacity of community to participate in priority setting and program development processes. • Strengthen information systems to support priority setting and program development processes. • Establish a knowledge translation plan across the program. • Ethical requirements, as well as local Aboriginal and Torres Strait Islander community process, are built into the program at the development stage.
Where we would like to be	
<ul style="list-style-type: none"> • Opportunity exists for Aboriginal and Torres Strait Islander communities to engage and partner with commissioners to assist in evaluation of community-led programs. • Aboriginal and Torres Strait Islander communities’ right to self-determine is recognised, with communities provided with the opportunity to lead or participate in programs as defined by communities. • Aboriginal and Torres Strait Islander communities have full opportunity to lead priority setting and program development processes, including development of program logic and indicators. • Aboriginal and Torres Strait Islander communities have full opportunity to utilise and develop methodologies that are consistent with their ways of knowing, doing and being. • Program responds to existing or emerging health needs articulated by the Aboriginal and Torres Strait Islander community. • Program responds to reducing inequities by addressing structural exclusion, access and racism while recognising the strengths of culture, rights of Aboriginal and Torres Strait Islander people, and priorities of communities. • Program is informed by evidence, which includes epidemiological data, community needs assessments and readily accessible previous evaluation reports. This includes the privileging of data and knowledge constructed and interpreted by communities. • Program development, including the program logic and indicators, is informed by Aboriginal and Torres Strait Islander understandings and concepts of health. • Establish processes to ensure program’s accountability to Aboriginal and Torres Strait Islander community. • Normative expectations that program and partnerships address priority areas for improving health equity identified by community. • Strengthen information systems that inform priority setting and program development processes. • Aboriginal and Torres Strait Islander preferences for governance, as well as engagement, are built into the whole program. • Protocols pertaining to Aboriginal and Torres Strait Islander data sovereignty and intellectual property are built across the program. • Ethical requirements, as well as local Aboriginal and Torres Strait Islander community processes, are built into the program at the development stage. • Establish a knowledge translation plan across the program. • Support and enhance the existing skills and knowledge of Aboriginal and Torres Strait Islander people and communities to be able to participate across the decision-making process. • Support and enhance the existing skills and knowledge of commissioners to work competently and respectfully across Aboriginal and Torres Strait Islander health and wellbeing. • Ensure that a culturally safe approach is integrated across the program. • Ensure program funding structure supports capacity strengthening across the project. 	

Implementing programs to improve Aboriginal and Torres Strait Islander health

Where we are coming from

- Current program implementation is overwhelmingly top-down.
- There is limited evidence of equal partnerships between implementers and Aboriginal and Torres Strait Islander communities.
- Engagement is inconsistent across programs as there is no requirement for implementers to engage or partner with Aboriginal and Torres Strait Islander communities and other stakeholders, such as service providers.
- Opportunity and capacity for Aboriginal and Torres Strait Islander communities to participate in implementation of programs is inconsistent across current practice.
- Accountability to Aboriginal and Torres Strait Islander communities is not well integrated into existing program implementation.
- Implementers do not widely support and enhance existing skills and knowledge of Aboriginal and Torres Strait Islander people and communities.
- Implementers do not widely support and enhance information systems that provide information on program implementation and effectiveness, or support Aboriginal and Torres Strait Islander people to work across information systems.
- There are inconsistent engagement requirements expected of implementers, which translates to few opportunities for ongoing mutual knowledge exchange.

Where we are moving to

- Set up (long-term) partnerships between program implementers/ACCOS/Aboriginal and Torres Strait Islander community to build capacity around program implementation.
- Establish program governance that engages with partnerships and enables Aboriginal and Torres Strait Islander leadership (this may occur at multiple levels for some programs).
- Build Aboriginal and Torres Strait Islander capacity to support program implementation through training and employment over the long term.
- Implement processes to ensure program's accountability to individuals, families and communities.
- Strengthen information systems to provide information on program implementation and effectiveness.
- Build Aboriginal and Torres Strait Islander capacity to support information systems through training and employment over the long term.
- Create opportunities for ongoing mutual knowledge exchange.
- Ensure program funding structure supports capacity building around program implementation and information strengthening.

Where we would like to be

- Opportunity and capacity exist for Aboriginal and Torres Strait Islander communities to solely implement programs, lead implementation or participate in implementation as defined by communities.
- Support and enhance partnerships between program implementers/ACCOS/Aboriginal and Torres Strait Islander community to continue to strengthen capacity around program implementation.
- Aboriginal and Torres Strait Islander preferences for governance, as well as engagement and partnership, are built into the whole program.
- There is opportunity for Aboriginal and Torres Strait Islander leadership (this may occur at multiple levels for some programs).
- Support and enhance the existing skills and knowledge of Aboriginal and Torres Strait Islander people and communities around program implementation through activities such as, but not limited to, training and employment over the long term.
- Support and enhance the existing skills and knowledge of implementers to work competently and respectfully in Aboriginal and Torres Strait Islander health.
- Implement processes to ensure program implementers' accountability to Aboriginal and Torres Strait Islander communities.
- Strengthen information systems to provide information on program implementation and effectiveness.
- Support and enhance Aboriginal and Torres Strait Islander peoples' knowledge and skills around support information systems.
- Create opportunities for ongoing mutual knowledge exchange.
- Ensure program funding structure supports capacity building around program implementation and information strengthening.
- Tenders for evaluation include criteria that require evaluators to be racially literate and experienced and have an understanding of Aboriginal and Torres Strait Islander health and state ethical requirements, and the review process includes Aboriginal and Torres Strait Islander communities.

Evaluating programs to improve Aboriginal and Torres Strait Islander health

Where we are coming from

- Current evaluation of programs is overwhelmingly top-down, led by evaluators, with varying levels of engagement and involvement by Aboriginal and Torres Strait Islander communities.
- Data governance and data sovereignty issues are not widely accounted for in existing evaluations.
- Knowledge is largely constructed and interpreted by evaluators with unrealised potential for mutual knowledge exchange.
- Accountability to Aboriginal and Torres Strait Islander communities is not well integrated into existing program evaluation.
- Evaluators do not widely utilise, support and enhance the existing skills and knowledge of Aboriginal and Torres Strait Islander people and communities.
- Evaluators do not widely support and enhance information systems that provide information on program implementation and effectiveness, or support Aboriginal and Torres Strait Islander people to work across information systems.
- There is evidence that some evaluations have funds tied to supporting and enhancing the skills and knowledge of Aboriginal and Torres Strait Islander communities to participate in evaluation, but most evaluations do not.

Where we are moving to

- Establish evaluation governance that engages with program governance and enables Aboriginal and Torres Strait Islander leadership (this may occur at multiple levels for some programs).
- Establish processes (e.g. MoU) to ensure evaluation accountability to Aboriginal and Torres Strait Islander community, including issues of data sovereignty.
- Develop knowledge translation/dissemination plan.
- Refine program logic and develop evaluation measures to reflect shared agenda.
- Create opportunities for ongoing mutual knowledge exchange.
- Minimise load/replication of data collection from program implementers/ACCOS/Aboriginal and Torres Strait Islander community.
- Build Aboriginal and Torres Strait Islander evaluation capacity through training and employment over the long term.
- Strengthen information systems to provide information on program evaluation.
- Build Aboriginal and Torres Strait Islander capacity to support information systems through training and employment over the long term.
- Ensure program funding structure supports capacity building around evaluation and information strengthening.
- Develop institutions to support capacity building around evaluation and information strengthening.

Where we would like to be

- Opportunity and capacity exists for Aboriginal and Torres Strait Islander communities to solely evaluate programs, lead evaluations or participate in evaluations as defined by communities.
- Establish evaluation governance that engages with program governance and enables Aboriginal and Torres Strait Islander leadership (this may occur at multiple levels for some programs).
- For partnerships, establish processes (e.g. MoU) to ensure evaluation accountability to Aboriginal and Torres Strait Islander community, including issues of data sovereignty.
- Review and refine knowledge translation/dissemination plan.
- Refine program logic and indicators so they continue to reflect the agenda of Aboriginal and Torres Strait Islander communities.
- Create opportunities for ongoing mutual knowledge exchange.
- Minimise load/replication of data collection from program implementers/ACCOS/Aboriginal and Torres Strait Islander community.
- Opportunity for Aboriginal and Torres Strait Islander communities to construct evaluation data and interpret such data.
- Support and enhance the existing skills and knowledge of Aboriginal and Torres Strait Islander people and communities around evaluation, through activities such as, but not limited to, training and employment over the long term.
- Support and enhance Aboriginal and Torres Strait Islander peoples' knowledge and skills around support information systems.
- Support and enhance the existing skills and knowledge of evaluators to work competently and respectfully in Aboriginal and Torres Strait Islander health.
- Ensure program funding structure supports and enhances capacity around evaluation and information strengthening.
- Develop institutions to support capacity building around evaluation and information strengthening.

Knowledge translation

Where we are coming from

- Recommendations from evaluations do not appear to be widely implemented, with findings from evaluations not translated into action or informing practice.
- There is a need for greater transparency in terms of making tenders, evaluation findings and reports available.
- Across evaluations, data governance protocols are not widely developed, particularly with regards to ownership, access and use of data.
- There is no clear accountability of commissioners to ensure that findings are implemented or that successful programs are resourced.

Where we are moving to

- Ensure evaluation accountability processes to Aboriginal and Torres Strait Islander communities are implemented.
- Ensure evaluation findings/data are available to participating Aboriginal and Torres Strait Islander communities.
- Build capacity around the use of evaluation findings/ data in participating Aboriginal and Torres Strait Islander communities.
- Ensure program documentation, evaluation briefs, request for tender documentation and evaluation reports are publicly available in perpetuity.
- Develop policy/program response to evaluation reports.
- Ensure policy/program response to evaluation reports is publicly available in perpetuity.
- Identify next steps developing the evidence base around the program.

Where we would like to be

- Opportunity and capacity exist for Aboriginal and Torres Strait Islander communities to lead or participate in knowledge translation activities in ways suitable to communities.
- Ensure evaluation accountability processes to Aboriginal and Torres Strait Islander communities are implemented.
- Ensure evaluation findings/data are available and in a format suitable to participating Aboriginal and Torres Strait Islander communities.
- Support and enhance the capacity around the use of evaluation findings/data in participating Aboriginal and Torres Strait Islander communities.
- Ensure program documentation, evaluation briefs, request for tender documentation and evaluation reports are publicly available in perpetuity.
- Develop policy/program response to evaluation reports.
- Ensure policy/program response to evaluation reports is publicly available in perpetuity.
- Support Aboriginal and Torres Strait Islander communities to identify next steps developing the evidence base around the program.
- Support and enhance the existing skills and knowledge of Aboriginal and Torres Strait Islander people and communities to develop and implement policy.

Key findings

The review highlighted strengths and weaknesses in how evaluations are currently conducted. Some of these limitations derive from current conceptualisations of ethical practice in evaluation. Key findings are summarised below.

- Aboriginal and Torres Strait Islander communities often do not receive feedback about evaluation findings or information about responses to evaluation. This limits both the real and perceived benefits of evaluation to Aboriginal and Torres Strait Islander communities.
- Existing ethical guidelines are often not specified in tenders or applied in evaluations.
- Ethical guidelines are primarily tailored to investigator-driven research. The guidelines deal with the relationship between the researchers and researched. Evaluation involves various parties and ethical responsibilities should be shared between them based on roles and capabilities.
- Lack of access to information about evaluations and their findings is a significant barrier to building the evidence base in Aboriginal and Torres Strait Islander health. It also prevents evidence-based priority setting and quality assurance processes around evaluation.
- There was no clear evidence of development or support for Aboriginal and Torres Strait Islander leadership in evaluation.
- Improving the benefit of evaluations for Aboriginal and Torres Strait Islander people requires developing ethical frameworks that include all parties involved in evaluation.

Research question 3

What would be the key elements required to support and advance Aboriginal and Torres Strait Islander community-level engagement in relation to policy, programs and services evaluation to inform local decision-making processes?

Key issues

Key issues need to be addressed to support and advance Aboriginal and Torres Strait Islander community-level engagement in relation to policy programs and services evaluation. These include the need to:

- make evaluation relevant to communities
- share the benefits
- orientate ethics to benefit
- enact and evaluate principles for working with Aboriginal and Torres Strait Islander people
- promote data sovereignty
- support Aboriginal and Torres Strait Islander leadership in evaluation
- develop capacity for commissioning Aboriginal and Torres Strait Islander evaluation.

Make evaluation relevant to communities

Evaluation practice recognises the need to make what is measured in evaluations valid and relevant from a community perspective, and positive initiatives have strengthened the engagement of communities in the design of evaluations through co-design. However, it is also important that communities are involved in the development of performance frameworks and program planning. The ability of evaluation to orientate itself to community needs is constrained if the community has not had input into developing higher-level priorities that inform performance frameworks and the development of a program. Aboriginal and Torres Strait Islander input at any level in any part of the process is valuable; however, self-determination involves programs being oriented to the needs of Aboriginal and Torres Strait Islander people at the highest level. When this does not occur, the different players in evaluations are constrained in their ability to deliver optimal results from a community perspective. Figure 17 outlines how these constraints impact evaluation.

Box 6: ‘We need to decolonise the whole system’

The *Aboriginal and Torres Strait Islander Health Performance Framework* (HPF) (AIHW 2017) was developed to support a comprehensive and co-ordinated effort across and beyond the health sector to address the complex and inter-related factors that contribute to health outcomes experienced by Aboriginal and Torres Strait Islander Australians. The HPF report includes 68 performance measures across three tiers:

- health status and outcomes
- determinants of health, including socio-economic and behavioural factors
- health system performance.

The performance measures have been criticised because they are orientated towards what is easily and reliably measured in existing data systems rather than what is most valuable to Aboriginal and Torres Strait Islander people (Pholi 2009; Walter & Andersen 2013). However, they are not necessarily most valuable to people designing and delivering programs either. The effect is that rather than programs focusing on the needs of Aboriginal and Torres Strait Islander people—and this influencing the choice of performance framework—they are oriented to the HPF, and consideration of the needs of Aboriginal and Torres Strait Islander people is constrained by these parameters.

The idea of performance frameworks is to focus systems on achieving outcomes; however, if a performance framework does not resonate with the interests of those it is intended to serve, this can be counterproductive and limit the ability of programs and, in turn, evaluations to optimally serve the needs of the population. Overall, the HPF is effective in influencing programs and policies and this is, in itself, an achievement and a reflection of a willingness to shift. However, improving benefit for Aboriginal and Torres Strait Islander people will require developing a HPF that reflects their values.

The overarching priorities of government are articulated in performance frameworks (in health, the *Aboriginal and Torres Strait Islander Health Performance Framework* (AIHW 2017)). Performance frameworks ideally should focus on what should be measured to show that a particular priority has been met, but they are often oriented to existing indicator sets that vary in the extent to which they capture desired change. Programs are then linked to performance frameworks. In turn, evaluations are linked to the logic of the program. This means that program development, implementation and performance are often misaligned with core values and the rationale underpinning the priorities as originally defined as outlined in Box 6. Although the introduction of shared values at any stage of the process can lead to improvements in terms of the benefits delivered to Aboriginal and Torres Strait Islander people, these will be constrained (as shown in Figure 17).

Consider a hypothetical example where the performance indicator to be addressed is a reduction in the mortality gap between Aboriginal and Torres Strait Islander people and other Australians. The most direct way to achieve this goal in a restricted timeframe is to improve the management of chronic disease among adults, and a program is designed to achieve this. However, consultation conducted around the evaluation reveals a preference in the community for a more holistic focus on the social determinants of health throughout the lifespan. The evaluation can note this, but the focus of the evaluation will be on chronic disease management among adults because this is the only thing that can be influenced by the program. Additional data may be collected to inform future program design but limits to evaluation budgets will strongly constrain the extent to which this occurs. Alternatively, if there was a consultative process around program design, community preferences would manifest in the program. The program would address social determinants of health over the lifespan and the evaluation would reflect the program.

Figure 17: The interaction of performance frameworks, programs and evaluation



Box 7: My Life, My Lead— Aboriginal and Torres Strait Islander engagement in national health policy

A key criterion of ethical evaluation is the involvement of stakeholders from the very beginning of both program and evaluation design. This allows stakeholder needs and perspectives to shape program and evaluation development, leading to evaluation results that are more relevant and consistent with stakeholder priorities. The governance and engagement strategy of the second stage of the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023* (Department of Health 2013) was to strengthen Aboriginal and Torres Strait Islander leadership and ensure strong input from all relevant stakeholders in designing the plan. Informing the Implementation Plan represents one objective of the Department of Health’s Indigenous Health Division Evaluation Strategy, which aims to support evaluation in the Indigenous Health Division to improve program delivery and inform evidence-based policy.

The Implementation Plan Advisory Group (IPAG) was convened in 2017 to help structure the second stage of the Implementation Plan. IPAG membership includes representatives from the National Health Leadership Forum, NACCHO, the Department of Health, the Department of the Prime Minister and Cabinet, the National Aboriginal and Torres Strait Islander Health

Standing Committee of the Australian Health Ministers’ Advisory Council, and the Australian Institute of Health and Welfare.

The IPAG “*My Life my Lead*” Consultation 2017 was undertaken to allow input to the Implementation Plan from a breadth of stakeholders, including Aboriginal and Torres Strait Islander communities and leaders, government agencies, non-government organisations and private sector entities. As part of the consultation, an online submission process was used and 13 face-to-face forums were held in capital cities and regional centres around Australia. Following a review of the literature and expert presentations, nine key determinants were identified as being particularly relevant and were used to structure the forums and online submissions.

- Approximately six hundred people attended the forums and more than a hundred written consultations were received. From these, key themes emerged:
- recognise the centrality of culture and family—as enablers and protectors
- partner with communities to build capacity, embed participation and support longer-term, co-ordinated, place-based approaches
- recognise and address the impacts of underlying trauma
- enhance access to health, education, employment and social services by addressing systemic racism and enhancing cultural competency.

However, because such a program may not be the most direct way to achieve the goal of reducing differentials in mortality, both the program and evaluation may be seen as misguided. Consequently, even if the program is successful in relation to its own objectives, it may be viewed as a failure. The optimal approach would be to have values aligned throughout the process. This would not only improve benefits to Aboriginal and Torres Strait Islander people but also improve transparency and accountability for government by providing a clear line of sight between performance frameworks, program activity and evaluation. An example of positive progress in this area is the development of the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* (Department of Health 2013). The consultation process for the plan is outlined in Box 7.

Share the benefits

Beyond the community’s role in the design and implementation of evaluation, there is a clear imperative to ensure that the program planning and evaluation cycle is transparent to communities so that they feel that participating in evaluation is a meaningful exercise. This is unlikely to happen if communities feel that evaluations do not convey information that is meaningful to them, do not see the products of evaluations and do not see actions resulting from them. Communities often feel that evaluations only lead to reports that ‘sit on shelves gathering dust’. Although in some cases this may be true, communities are not always informed about how the information they have provided has influenced programs and policy. Engagement in evaluations that have no tangible

benefit to a community is a cost to that community. From a community perspective the same is true of evaluations where the community is unaware of any benefit. Most evaluations have a clear plan for the dissemination of the results. All evaluation plans should include a communication plan for participating communities. However, in reality, few evaluations include a specific plan for the dissemination of information about the impacts of the evaluation—in particular, those impacts that occur after the evaluation is complete. As discussed in the section on Research question 2 in this chapter, an important part of reinforcing the value of evaluation to communities is sharing the information about its impacts.

Orientate ethics to benefit

Ethics in evaluation, like ethics in research, primarily focus on the relationship between individual/community participants and the evaluator. Benefit to Aboriginal and Torres Strait Islander communities could be enhanced by envisaging ethics as a set of responsibilities that are shared among all parties in evaluation and by explicitly outlining how these obligations will be met. Under current ethical guidelines, Aboriginal and Torres Strait Islander engagement in evaluation is critical, but this review suggests that these guidelines may not always be applied. An expanded ethical approach would encompass the inclusion of Aboriginal and Torres Strait Islander people in the other phases of the planning and evaluation cycle and would in turn increase their voice. This is outlined in more detail in the section on Research question 5 in this chapter.

Enact and evaluate principles for working with Aboriginal and Torres Strait Islander people

In the section on Research question 1 in this chapter, the review shows that agreed principles for working with Aboriginal and Torres Strait Islander people are often not evaluated. Their explicit inclusion in evaluations would improve practice.

Promote data sovereignty

Data sovereignty is critical to self-determination (Pholi 2009; Walter & Andersen 2013). Accordingly, Aboriginal and Torres Strait Islander people should have both leadership and ownership with respect to data collected as part of evaluation. There are currently barriers to this. The first relates to the accessibility of documents and reports. At present, publicly accessible documents and reports are not preserved in the public domain so are not available historically. In the case of tender documents, this is often because there is no archive plan. In the case of evaluation reports, this is often because links to the reports become defunct rather than any reason to limit availability. There are also documents and reports that are not initially publicly accessible. However, it is often not clear whether they should or will remain inaccessible in perpetuity. There should be clear processes to ensure that all evaluation documents become and remain publicly accessible. The Australian Indigenous HealthInfoNet currently provides

access to evaluation reports by linking to government sites and abstracts. Although this resource is comprehensive, well-regarded and authoritative in its reviews of policy, its utility is limited to what is available on government websites. (Note: The Australian Indigenous HealthInfoNet also includes peer-reviewed literature but it is not subject to the same concerns.) Expansion to include direct archiving may assist in development.

Second, there is often no process for evaluation data to be made available to communities. Access to data needs to be consistent with the ethical approval to collect that data. It should also be noted that some data associated with evaluations may not be shared because of restricted access under privacy legislation or the *National Health Act 1953* (Cth), although in some cases these data would be able to be requested separately. However, in general there should be a process to ensure that if communities wish to access data, they can do so in a manner consistent with ethical approval and data management processes. At present, however, in communities the capacity for data storage and analysis is limited. Fostering data ownership at community level will require expanding resources in this area. In the interim, third-party data managers may provide an acceptable option. It should be noted that this would require significantly expanding the function of any existing organisation.

Support for Aboriginal and Torres Strait Islander leadership in evaluation

Expansion of the participation of Aboriginal and Torres Strait Islander people in co-designing and leading evaluation will require access to training to support these activities. Relatively few training opportunities are targeted specifically at increasing evaluation expertise in Aboriginal and Torres Strait Islander health. One exception is the Research Excellence in Aboriginal Community Controlled Health (REACCH) project. The evaluation of REACCH aimed to assess, in part, the extent to which the program supported individual-level research capacity building and the development of an organisational culture of research and evaluation within participating ACCHOs (Nathan, Bunde-Birouste & Croft 2016). REACCH provided in-house workshops, research officer training and project mentoring for ACCHOs to support understanding of research and organisational research capacity. In examining existing research capacity, readiness and priorities of ACCHOs, the evaluation found that many organisations had a history of involvement in research instigated by outside investigators, but a limited understanding of the purpose of research and how it could benefit them or their communities. At the same time, however, there was a high level of willingness to learn, with strong attendance at workshops designed to build individual and organisational research capacity (Nathan et al. 2016). The program was found to be largely successful, and the role of NACCHO in identifying ACCHOs that were in a position to take on the work of building research capacity was crucial. Throughout the REACCH evaluation, a recurrent theme was balancing the main priorities

of ACCHOs to provide services with the time and effort required to engage in building research skills. The ongoing support and engagement of local research officers allowed ACCHOs to develop at their own pace (Nathan, et al. 2016). Further implementation of strategies such as those included in REACCH may help to build capacity for ACCHOs and other Aboriginal and Torres Strait Islander organisations to lead and more strongly engage with evaluation practice.

Training to specifically support Aboriginal and Torres Strait Islander leadership in evaluation will improve benefits to the community both through employment and by improving evaluation itself. Many commissioners do consider the employment and engagement of Aboriginal and Torres Strait Islander people in the criteria for selecting evaluators. This would be strengthened by considering support for Aboriginal and Torres Strait Islander leadership in evaluation criteria.

Development of capacity for commissioning Aboriginal and Torres Strait Islander evaluation

Data from some of the consultations and the workshop in this project suggested that some evaluation commissioners lack experience in working with Aboriginal and Torres Strait Islander communities. It has been argued that this contributes to the inconsistent application of principles for working with Aboriginal and Torres Strait Islander people. For example, appropriate consultation processes require time and resources that are often not included in evaluations. This project did not directly collect any data around the experience of evaluation commissioners in Aboriginal and Torres Strait Islander health and the project's engagement was primarily with commissioners with strong content area expertise. However, greater training for evaluation commissioners in principles for working with Aboriginal and Torres Strait Islander communities may have a range of benefits.

Key findings

Key issues need to be addressed to support and advance Aboriginal and Torres Strait Islander community-level engagement in relation to policy programs and services evaluation. These include:

- improving the benefits of evaluations for Aboriginal and Torres Strait Islander people, which involves ensuring that Aboriginal and Torres Strait Islander values resonate throughout the system from the *Aboriginal and Torres Strait Islander Health Performance Framework* (AIHW 2017) to local program development
- a clear imperative to ensure that the program planning and evaluation cycle is transparent to communities so that they feel that participating in evaluation is a meaningful exercise

- data sovereignty, which is critical to self-determination; Aboriginal and Torres Strait Islander people should have both leadership and ownership with respect to evaluation reports and data on their communities
- the need for greater support for Aboriginal and Torres Strait Islander leadership in evaluation and participation in co-design
- greater training for evaluation commissioners in principles for working with Aboriginal and Torres Strait Islander communities, which may have a range of benefits.

Research question 4

Are there key 'indicators' or evaluation questions for which data could be collected relevant to each identified element at the different levels?

The evaluation framework (Part A) presented in Table 5 is a guide to the stated principles of Australian governments for working with Aboriginal and Torres Strait Islander people. The principles would therefore be expected to underpin any policy, program or service that aims to improve Aboriginal and Torres Strait Islander health and wellbeing and should be included as part of the evaluation for such initiatives.

The principles were identified through examining Australian Government and state/territory health planning documents in order to understand the underlying values in the design and development of programs to address Aboriginal and Torres Strait Islander health and wellbeing and by reviewing existing evaluations. The indicators provide examples of the types of actions that would be expected to support these principles in the design, development and implementation of Aboriginal and Torres Strait Islander health policies, programs and services. The outcome indicators are measurable criteria that would allow an evaluator to ascertain whether the principles are being applied in practice. The framework does not aim to be prescriptive and, depending on the initiative being evaluated, some indicators may not be applicable. We have added additional principles and indicators around recognising Aboriginal and Torres Strait Islander strengths based on the workshop.

Table 5: Evaluation framework to Improve Aboriginal and Torres Strait Islander Health, Part A: What to evaluate—key principles and indicators of programs

Principle	
Partnerships with Aboriginal and Torres Strait Islander organisations and communities	
Description	
<p>Partnership and shared ownership between Aboriginal and Torres Strait Islander people, communities, ACCOs, governments and other service providers, which operates at all levels of health planning, delivery and evaluation to engage with communities regarding their goals and priorities for health. Partnership refers to a co-ordinated and collaborative approach through knowledge exchange, information sharing and the pooling of resources, where possible. Effective partnerships ensure Aboriginal and Torres Strait Islander people and communities’ central involvement in designing, planning, development, implementation and evaluation of strategies for better health and wellbeing. Supportive knowledge, skills, behaviours and systems are required to establish relationships and build effective long-term partnerships so that Aboriginal and Torres Strait Islander people and communities can manage and improve their health status through leadership, policy, planning, quality improvement, education and training, funding and service delivery.</p>	
Outcomes	Indicators
<ul style="list-style-type: none"> Aboriginal and Torres Strait Islander people, communities and ACCOs are respected as partners in program provision and are informed and own the decisions. Partners work at all stages with local Aboriginal and Torres Strait Islander Elders and leaders as equal partners in design, planning and evaluation to ensure that local cultural expectations are addressed. External health services partner with local Aboriginal and Torres Strait Islander communities to inform their program, including how such services recruit and retain staff to meet the needs of Aboriginal and Torres Strait Islander communities. Partnerships with ACCOs and Aboriginal and Torres Strait Islander communities are developed and are sustainable through adequate resourcing and support. Aboriginal and Torres Strait Islander peoples, organisations and communities’ right to self-determine is recognised and informs program partnership arrangements. 	<ul style="list-style-type: none"> Percentage of Aboriginal and Torres Strait Islander representatives on advisory and governance bodies. Percentage of Aboriginal and Torres Strait Islander organisations represented on advisory and governance bodies. Strategies to ensure equity in the partnership (e.g. sharing of resources, co-chairing arrangements). Terms of reference of advisory and governance bodies. MoUs or other formal agreements documenting partnership. Strategies for sharing power within partnerships. Involvement of Aboriginal and Torres Strait Islander people in decision making. Support for deliberative processes. Strength of the partnership. Partnership has achieved its goals. Processes to identify and address challenges.

Principle

Shared responsibility

Description

Partnership and shared ownership between Aboriginal and Torres Strait Islander people, communities, ACCOs, governments and other service providers, which operates at all levels of health planning, delivery and evaluation to engage with communities regarding their goals and priorities for health. Partnership refers to a co-ordinated and collaborative approach through knowledge exchange, information sharing and the pooling of resources, where possible. Effective partnerships ensure Aboriginal and Torres Strait Islander people and communities' central involvement in designing, planning, development, implementation and evaluation of strategies for better health and wellbeing. Supportive knowledge, skills, behaviours and systems are required to establish relationships and build effective long-term partnerships so that Aboriginal and Torres Strait Islander people and communities can manage and improve their health status through leadership, policy, planning, quality improvement, education and training, funding and service delivery.

Outcomes

- Aboriginal and Torres Strait Islander people, communities and ACCOs are respected as partners in program provision and are informed and own the decisions.
- Partners work at all stages with local Aboriginal and Torres Strait Islander Elders and leaders as equal partners in design, planning and evaluation to ensure that local cultural expectations are addressed.
- External health services partner with local Aboriginal and Torres Strait Islander communities to inform their program, including how such services recruit and retain staff to meet the needs of Aboriginal and Torres Strait Islander communities.
- Partnerships with ACCOs and Aboriginal and Torres Strait Islander communities are developed and are sustainable through adequate resourcing and support.
- Aboriginal and Torres Strait Islander peoples, organisations and communities' right to self-determine is recognised and informs program partnership arrangements.

Indicators

- Percentage of Aboriginal and Torres Strait Islander representatives on advisory and governance bodies.
- Percentage of Aboriginal and Torres Strait Islander organisations represented on advisory and governance bodies.
- Strategies to ensure equity in the partnership (e.g. sharing of resources, co-chairing arrangements).
- Terms of reference of advisory and governance bodies.
- MoUs or other formal agreements documenting partnership.
- Strategies for sharing power within partnerships.
- Involvement of Aboriginal and Torres Strait Islander people in decision making.
- Support for deliberative processes.
- Strength of the partnership.
- Partnership has achieved its goals.
- Processes to identify and address challenges.

Principle

Engagement with Aboriginal and Torres Strait Islander people and communities

Description

Engagement is based on the acknowledgment of Aboriginal and Torres Strait Islander communities' right to control health and wellbeing programs in their local community and/or region. Engaging with Aboriginal and Torres Strait Islander people, organisations and communities involves their full and ongoing participation in all levels of decision making to ensure active involvement in the design and delivery of programs. Engagement with Aboriginal and Torres Strait Islander community members, organisations and representative structures serves to ensure all policy and activity has their support, and that they have input into the design, monitoring and evaluation of initiatives, programs and services. ACCOs provide unique contributions in delivering holistic, comprehensive and culturally appropriate health care to Aboriginal and Torres Strait Islander communities, and their engagement and involvement are central to improving Aboriginal and Torres Strait Islander health outcomes.

Outcomes

Indicators

- Aboriginal and Torres Strait Islander people, communities' and ACCOs' involvement is embedded within program delivery, structures, policies, procedures and governance.
- Continued engagement and collaboration between Aboriginal and Torres Strait Islander communities, including ACCO sector and government and mainstream service providers.
- Participation of Aboriginal and Torres Strait Islander people and communities in relevant formal advisory and governance bodies.
- Planning of dedicated services for Aboriginal and Torres Strait Islander peoples involves community consultation where Aboriginal and Torres Strait Islander people, communities and ACCOs inform the direction of the program.
- Consultation with local communities is undertaken for all changes, problem solving and improvements, and is respectful of community protocols.
- Aboriginal and Torres Strait Islander people, communities and ACCOs are engaged across the planning, design and implementation stages of a program and its evaluation.

- Engagement of Aboriginal and Torres Strait Islander people in all phases of the program planning and evaluation cycle.
- Percentage of Aboriginal and Torres Strait Islander representatives on advisory and governance bodies.
- Percentage of Aboriginal and Torres Strait Islander organisations represented on advisory and governance bodies.
- Terms of reference of advisory and governance bodies.
- Increased number of Aboriginal and Torres Strait Islander people engaged in the development of new health services and programs or changes to existing initiatives.
- Number of meetings seeking community input.
- Number and type of mechanisms for engagement of universal health services with ACCOs or Aboriginal and Torres Strait Islander communities.
- Involvement of Aboriginal and Torres Strait Islander people in decision making.
- Support for deliberative processes.

Principle

Capacity building of Aboriginal and Torres Strait Islander communities

Description

Capacity building refers to developing and providing knowledge, skills, resources and systems to support Aboriginal and Torres Strait Islander people and communities to engage in health services design, development, implementation and evaluation. This may involve providing employment or training opportunities and encouragement of Aboriginal and Torres Strait Islander people to take on leadership or management positions, and/or ensuring adequate representation of Aboriginal and Torres Strait Islander communities and organisations on advisory and governance bodies.

Outcomes

- Aboriginal and Torres Strait Islander people, communities and ACCOs are respected as partners in program provision and are informed and own the decisions.
- Partners work at all stages with local Aboriginal and Torres Strait Islander Elders and leaders as equal partners in design, planning and evaluation to ensure that local cultural expectations are addressed.
- External health services partner with local Aboriginal and Torres Strait Islander communities to inform their program, including how such services recruit and retain staff to meet the needs of Aboriginal and Torres Strait Islander communities.
- Partnerships with ACCOs and Aboriginal and Torres Strait Islander communities are developed and are sustainable through adequate resourcing and support.
- Aboriginal and Torres Strait Islander peoples, organisations and communities' right to self-determine is recognised and informs program partnership arrangements.

Indicators

- Percentage of Aboriginal and Torres Strait Islander representatives on advisory and governance bodies.
- Percentage of Aboriginal and Torres Strait Islander organisations represented on advisory and governance bodies.
- Percentage of Aboriginal and Torres Strait Islander people recruited and employed.
- Percentage of Aboriginal and Torres Strait Islander people recruited and employed in management or leadership roles.
- Retention of Aboriginal and Torres Strait Islander workforce.
- Increased number of Aboriginal and Torres Strait Islander people engaged in the development of new health services and programs or changes to existing initiatives.
- Investment in training and employment opportunities for Aboriginal and Torres Strait Islander people.
- Aboriginal and Torres Strait Islander recruitment and employment commitments embedded into program planning.
- Aboriginal and Torres Strait Islander staff self-report high levels of employment satisfaction and support.
- ACCOs self-report increased capacity to respond to local health needs.
- Increase in services provided by Aboriginal and Torres Strait Islander people/ACCOs.
- Increase in Aboriginal and Torres Strait Islander people receiving services from Aboriginal and Torres Strait Islander people/ACCOs.

Principle

Equity

Description

A human rights-based approach is about providing equal opportunities for health by ensuring availability, accessibility, acceptability and quality health programs. A human rights approach is not necessarily about more programs, but about better programs through processes that enable Aboriginal and Torres Strait Islander people to participate in all levels of health care decision making. This includes ensuring that programs are physically and culturally accessible, are inclusive of the needs of Aboriginal and Torres Strait Islander people, incorporate Aboriginal and Torres Strait Islander ways of working, and enable Aboriginal and Torres Strait Islander people to achieve equitable health outcomes.

Outcomes

- Collaborative action taken on the determinants of health, with an emphasis on the social and cultural determinants of health.
- Evaluations of programs include identification of program gaps and development of culturally safe solutions.
- Ensuring that quality health programs are available, accessible and acceptable to Aboriginal and Torres Strait Islander people, communities and ACCOs.
- Programs target and respond to the needs of marginalised persons, including those within the Aboriginal and Torres Strait Islander community (i.e. disability, LGBTQI populations).

Indicators

- Collaborative process to identify cultural and social determinants of health to be harnessed/addressed by programs.
- Continuity of collaborative processes throughout the program cycle
- Monitoring of cultural and social determinants and health outcomes for Aboriginal and Torres Strait Islander people.
- Improved outcomes for Aboriginal and Torres Strait Islander people and groups from marginalised groups.
- Formal cultural competence processes related to:
 - Personnel recruitment/retention
 - Training/staff development
 - Language access/communication
 - Cultural competence-related grievance/complaints process
 - Community/participant input.
 - Consumer participation/satisfaction regarding cultural competence-related planning.
 - Staff participation/satisfaction regarding cultural competence-related planning.
 - Timely and accurate cultural competence-related data.
 - Review and response to cultural competence-related data.
- Improved outcomes for Aboriginal and Torres Strait Islander people and groups from marginalised groups.
- Audits and monitoring of strategies to promote equity of access among program staff.
- Reliable identification of Aboriginal and Torres Strait Islander participants in program.
- Assessment of barriers to and facilitators of availability, accessibility, acceptability and affordability of the program.
- Administrative and service delivery adaptations tailored to population in service area, including adaptations to improve access to program.
- Equity in program participation.

Principle

Accountability

Description

Accountability refers to the regular evaluation, monitoring and review of implementation as measured against indicators of success, with processes in place to share knowledge on what works and being responsive to monitoring and evaluation findings. Accountability applies to government, mainstream, and Aboriginal and Torres Strait Islander services and is necessary to understand the intended and unanticipated effects of program and policy implementation. It incorporates transparency in the allocation and use of funding, including the effective use of funds, and adequate and ongoing funding for necessary services, as well as establishing genuine and meaningful planning and services development partnerships with communities.

Outcomes

- Program aims are relevant to context and needs of Aboriginal and Torres Strait Islander community.
- Program has the support of Aboriginal and Torres Strait Islander community leaders.
- Aboriginal and Torres Strait community members are kept up-to-date about the progress and outcomes of the program and evaluation.
- Health services have sound quality improvement systems for the identification and communication of health care and cultural issues, and plan and implement improvements in partnership with Aboriginal and Torres Strait Islander staff, consumers and communities.
- Ongoing monitoring, evaluation and quality improvement of all strategies undertaken alongside implementation.
- Program is implemented in the manner planned, with any changes acknowledged and agreed upon.
- Program funders and/or sponsors respond to evaluation outcomes and recommendations.

Indicators

- Program aims align with stated Aboriginal and Torres Strait Islander community health needs and priorities.
- Number of Aboriginal and Torres Strait Islander community leaders who endorse the program.
- Number of Aboriginal and Torres Strait Islander organisations that participate in the program.
- Dissemination of information regarding program and evaluation progress and outcomes to the Aboriginal and Torres Strait Islander community is undertaken.
- Mechanisms to measure feedback show that Aboriginal and Torres Strait Islander communities are satisfied with program aims, progress and outcomes.
- Mechanisms to incorporate feedback from Aboriginal and Torres Strait Islander communities are in place.
- Indicators regarding Aboriginal health in service delivery agreements are met or exceeded.
- Program evaluation designed, planned and undertaken alongside program implementation in a co-ordinated approach.
- Process evaluation indicates that strategies were implemented in the manner planned or that changes were acknowledged and agreed upon.
- Response to evaluation from program funders and/or sponsors.

Principle

Evidence based

Description

Evidence-based policy and program approaches are two pronged. First, they involve the incorporation of established evidence into decision making to ensure programs are appropriate and effective and have the best chance of achieving the desired outcomes. Second, an evidence-based approach necessitates a robust process of program evaluation and the integration of evaluation outcomes into policy making and program design.

Outcomes

Indicators

- Ongoing monitoring, evaluation and quality improvement of all strategies implemented.
- Evaluation outcomes inform future policy and programs.
- A co-ordinated approach is taken to program design and evaluation.

- Evaluation reports are used in the program cycle.
- Key learnings are identified and can be used in the next iteration of the program.
- Existing evidence base is used in program design.
- Recommendations arising from evaluations are taken up in future policy and program design.

Research question 5

What would good practice evaluation at a policy or program level encompass?

Research for the health justice framework (Pratt & Loff 2014) has been adapted to the evaluation of Aboriginal and Torres Strait Islander programs in health and wellbeing (Table 6). Table 6 further develops the information presented in Table 4 by showing not only the tasks that should be completed but

also who has predominant responsibility in current evaluation models. Responsibilities could be shared or in different models redistributed to those most able to deliver them. Overall, the key issue is to ensure that responsibilities are met to deliver optimal results. Current conceptualisations of ethics in evaluation and the responsibilities of evaluators do not encompass all the issues required to achieve this. All parties in evaluation have important capabilities that could be harnessed if ethical practice was refocused to health benefit.

Table 6: Evaluation framework to Improve Aboriginal and Torres Strait Islander Health, Part B: How to evaluate—adaptation of the research for a health justice framework*

Evaluators ○

Commissioners ●

Program implementers ●

Developing programs to improve Aboriginal and Torres Strait Islander health

- Engage Aboriginal and Torres Strait Islander communities and other stakeholders, such as service providers
- Consider/conduct/share review of epidemiological data/community assessment and other relevant data
- Review data on program effectiveness and previous evaluations
- Ensure program responds to existing or emerging health needs articulated with community
- Ensure program logic is developed and reflects shared agenda
- Establish processes to ensure program's accountability to Aboriginal and Torres Strait Islander community
- Ensure normative expectations that program and partnerships address priority areas for improving health equity identified by community
- Strengthen the capacity of community to participate in priority setting and program development processes
- Strengthen information systems to support priority setting and program development processes
- Establish a knowledge translation plan across the program
- Build ethical requirements, as well as local Aboriginal and Torres Strait Islander community process, into the program at the development stage

Implementing programs to improve Aboriginal and Torres Strait Islander health

- Set up (long-term) partnerships between program implementers/ACCOs/Aboriginal and Torres Strait Islander community to build capacity around program implementation
- Establish program governance, engaging with partnerships and enabling Aboriginal and Torres Strait Islander leadership (this may occur at multiple levels for some programs)
- Build Aboriginal and Torres Strait Islander capacity to support program implementation through training and employment over the long term
- Implement processes to ensure program's accountability to individuals, families and communities
- Strengthen information systems to provide information on program implementation and effectiveness
- Build Aboriginal and Torres Strait Islander capacity to support information systems through training and employment over the long term
- Create opportunities for ongoing mutual knowledge exchange
- Ensure program funding structure supports capacity building around program implementation and information strengthening

Evaluating programs to improve Aboriginal and Torres Strait Islander health

- Establish evaluation governance, engaging with program governance and enabling Aboriginal and Torres Strait Islander leadership (this may occur at multiple levels for some programs)
- Establish processes (e.g. MoUs) to ensure evaluation's accountability to Aboriginal and Torres Strait Islander community, including issues of data sovereignty
- Develop knowledge translation/dissemination plan
- Refine program logic and develop evaluation measures to reflect shared agenda
- Create opportunities for ongoing mutual knowledge exchange
- Minimise load/replication of data collection from program implementers/ ACCOs/Aboriginal and Torres Strait Islander community
- Build Aboriginal and Torres Strait Islander evaluation capacity through training and employment over the long term
- Strengthen information systems to provide information on program evaluation
- Build Aboriginal and Torres Strait Islander capacity to support information systems through training and employment over the long term
- Create opportunities for ongoing mutual knowledge exchange
- Ensure program funding structure supports capacity building around evaluation and information strengthening
- Develop institutions to support capacity building around evaluation and information strengthening

Knowledge translation

- Ensure evaluation accountability processes to Aboriginal and Torres Strait Islander communities are implemented
- Ensure evaluation findings/data are available to participating Aboriginal and Torres Strait Islander communities
- Build capacity around the use of evaluation findings/data in participating Aboriginal and Torres Strait Islander communities
- Ensure program documentation, evaluation briefs, request for tender documentation and evaluation reports are publicly available in perpetuity
- Develop policy/program response to evaluation reports
- Ensure policy/program response to evaluation reports are publicly available in perpetuity
- Identify next steps developing the evidence base around the program

* Adaptation of the research for a health justice framework (Pratt & Loff 2014)

Research question 6

Are there examples of program evaluations that have demonstrated good practice and what are the elements of these?

The project reference group and interim workshop members identified six case studies as good examples of principle-informed evaluation. These case studies were selected as diverse examples of evaluations that occur across Aboriginal and Torres Strait Islander health.

Each case study demonstrates a commitment to better evaluation practice in Aboriginal and Torres Strait Islander health through the integration of principles that we advocate for within this framework. While case studies demonstrate principle-informed approaches, they importantly also highlight some of the limitation of current practice and lessons for future evaluation.

Case studies identified and described in this report include the evaluations of the:

- Engaging Stakeholders in Identifying Priority Evidence-Practice Gaps and Strategies for Improvement (the ESP Project) (national)
- Heart Health cardiac rehabilitation program (Western Australia)
- Returning Home, Back to Community from Custodial Care Pilot program (national)
- Sentinel Sites Evaluation of the Indigenous Chronic Disease Package 2010–2014 (national)
- Stronger Communities for Children program (Northern Territory)
- Two Gathering Places in the Eastern Metropolitan Region of Melbourne (Victoria).

In addition to principle-informed approaches, many of these case studies demonstrate a high level of Aboriginal and Torres Strait involvement, solid knowledge translation process and commitment to ethical research. Some of the case studies also provide emerging examples of more Aboriginal-informed methodological approaches to evaluation.

Engaging Stakeholders in Identifying Priority Evidence-Practice Gaps and Strategies for Improvement (the ESP Project), Menzies School of Health Research

- Engaging Stakeholders in Identifying Priority Evidence-Practice Gaps and Strategies for Improvement (the ESP Project) was a nationwide continuous quality improvement (CQI) project that aimed to engage people who were working in policy, research and health services delivering primary health care for Aboriginal and Torres Strait Islander people to identify and respond to gaps in care.
- The program and evaluation were conducted by Menzies School of Health Research and the Centre of Research Excellence in Integrated Quality Improvement from late 2013 to 2016.
- The evaluation used a ‘developmental evaluation’ framework, where the evaluation was planned and built into the ESP Project from the outset and was conducted alongside the project to allow for continuous adaptation and project improvement.
- Central to the evaluation was engagement with key stakeholders, strong knowledge dissemination and translation processes, as well as organisational capacity building.

Using CQI data from 175 health services across Australia (38 ACCHOs and 137 government services), the main goal of the ESP Project was to engage people working in policy, research and health services delivering primary health care for Aboriginal and Torres Strait Islander people to identify and respond to gaps in care. It engaged multiple partners in knowledge translation.

Through collaboration and engagement, the ESP Project aimed to reduce health care disparities by strengthening the use of data to implement evidence-based health care within primary health care services across the areas of chronic disease, child health, maternal health, mental health, rheumatic heart disease and preventive health. Details about the evaluation and its methodology has been published and is publicly available (Laycock et al. 2016).

What are the key ethical principles demonstrated by the evaluation?

The principles of equity, improving access and strengthening evidence-based care underpin the project approach. Engagement was another key Aboriginal research principle embedded within the ESP Project. As part of the project, the Menzies research team used an ‘interactive dissemination’ process to facilitate engagement with health services and other stakeholders. The research team de-identified and analysed the CQI data to identify improvement priorities and trends in care before distributing the reports. Phases of reporting and online

feedback were used to gather input. People in different roles and organisations helped to distribute the reports through their networks, interpreted the data and completed surveys. The evaluator spoke of the participatory nature of the ‘interactive dissemination’ process and how this led to services being engaged to identify evidence practice gaps and barriers and to generate local responses.

Our CQI research is based on collaboration with services and an important principle of CQI is participatory interpretation. The ESP Project was designed to engage stakeholders in these processes on a wide scale. We said, ‘We need your knowledge and expertise, coming from different perspectives and working in Aboriginal and Torres Strait Islander health, to help interpret and use these data to improve care.’ We asked people who received the reports to share them through their networks and encourage others to participate in the surveys. **(Evaluation team member)**

What were some of the positive examples of evaluation practice?

The evaluation of the ESP Project used a developmental evaluation framework. The evaluation was planned and built into the ESP Project from the outset and was conducted alongside the project to allow for continuous adaptation, as described by the evaluator, who was part of the project team.

The evaluation was designed around the design of the project—the repeated reporting and feedback cycles enabled the team to continuously apply what we were learning about collecting, analysing and presenting information effectively, and supported engagement with data. **(Evaluation team member)**

This evaluation approach supported changes to the project and the evaluation in real time. Reflecting on the benefits of using this approach, the team member described how:

From the beginning of the project, developmental evaluation gave us opportunities to continually reflect and ask those ‘what, so what, now what’ evaluation questions as we went along—‘How well is this part of the project working? How are people responding? Can we make changes to strengthen that aspect? What are the implications? Let’s trial that change.’ Developmental evaluation supported us to be flexible and responsive to feedback. **(Evaluation team member)**

Through developmental evaluation, the project team developed and refined the design of the reports, processes and resources used to support the ESP Project. Findings about improvement priorities, barriers and strategies were presented in different formats for different audiences—full reports, plain language summaries, brief reports with key messages and journal articles. In this way, knowledge translation, evaluation and program implementation were highly intertwined.

Through surveys and interviews we also had the opportunity to find out how people were using the findings. That information is informing the research translation work that follows on from the project. **(Evaluation team member)**

Another strength of the ESP Project and evaluation was that they focused on supporting health services to strengthen their capacity to use data. As a team member reflected:

It’s offered aggregate CQI data that people have found useful for comparing with their local data... We used box-and-whisker plot graphs to present data and included an explanation of how to interpret them. We had feedback that people found them difficult to understand at first, but now appreciate their value for showing trends and variation in improvement data. **(Evaluation team member)**

Where are some areas where evaluation practice can be strengthened?

Despite its many strengths, it is important to recognise that evaluations of this scale, across multiple sites, have many partners and operate at the health-systems level, and it is often difficult to build strong Aboriginal governance, ownership and data sovereignty into the program and its evaluation. There is therefore a need to consider if and how Aboriginal communities and organisations are to shape system-level research.

Conclusions

A key strength of the ESP Project lies in the selected evaluation approach, as well as dissemination processes being built into the project from the beginning. The ESP Project is a system-wide research project that aims to strengthen systems for delivering health care for Aboriginal and Torres Strait Islander people. Much can be learned from its innovative methodology, collaborative approach, engagement, strong knowledge dissemination and translation processes, as well as through organisational capacity building.

Heart Health cardiac rehabilitation program, Derbarl Yerrigan Health Service

- In 2008 the Derbarl Yerrigan Health Service (DYHS) in Perth established a community-based cardiac rehabilitation program (Heart Health) in partnership with the Australian Heart Foundation, Royal Perth Hospital and Curtin University.
- Members of the Heart Health program reference group conducted an evaluation to demonstrate the efficacy of the program to improve the health and wellbeing of participants.
- Central to the evaluation (and program) was community ownership, accountability of the evaluators, holism, engagement with community, partnerships, Aboriginal involvement and leadership in every part of the evaluation, Aboriginal IP ownership and Aboriginal project governance.
- Although interviews, questionnaires and yarning sessions were included as part of the evaluation strategy, a limitation was that the evaluation focused more on physical health indicators and less on broader community holistic wellbeing information.

The Heart Health—'For Our People, By Our People'—cardiac rehabilitation program (hereafter, Heart Health), offered through DYHS, includes weekly exercise and education sessions for Aboriginal people with, and at risk of, cardiovascular disease and other chronic illnesses. Heart Health is a grassroots program with inbuilt evaluation that evolved from the bottom up, with the partnerships and project reference group initially forming from a community symposium on cardiovascular disease. A member of the project team reflected:

So we had key people engaged who had passions to see this actually unfold within WA, because they knew that according to the statistics, Aboriginal people didn't attend cardiac rehab in a hospital-based setting, and so were missing out completely, not just in interventions and treatment, but also follow-up care. This then began the journey of setting up here at Derbarl Yerrigan. (Project team member)

The program was an equity and evidence-based response to community needs. It was developed because statistics indicated higher cardiovascular disease mortality at younger ages, lower access to cardiac rehabilitation service and treatment gaps for Aboriginal people. The program and its evaluation were developed concurrently, with initial community consultation and focus groups shaping how the program could meet local community needs and preferences. The evaluation was designed and built into the program from the beginning, with the project serving as an evidence-building activity/proof-of-concept evaluation.

What are the key ethical principles demonstrated by the evaluation?

Aboriginal governance, engagement and partnership were integrated across the program and its evaluation. The overarching program and evaluation were overseen by a Steering Group with organisational membership from the project partners. Aboriginal governance on this group was facilitated through the involvement of Aboriginal individuals, as well as through involvement of Aboriginal organisations. The Steering Group partnership was based on acknowledgment of two-way learning approaches, which included the recognition that there was a need to respect the knowledge and experiences of Aboriginal communities, as well as strengthen the clinical capabilities of DYHS staff.

With Aboriginal voice provided by DYHS on the Steering Group, alongside placement of the program within DYHS, the Heart Health program and evaluation had a strong sense of local ownership by the Aboriginal community. This ownership meant that the program and evaluation had high community buy-in and that evaluators were accountable to the community to deliver. A Steering Group member said:

I'm going 'But without you guys, we wouldn't be able to deliver. If you don't come and you don't want to learn about yourselves. Then we won't have a job and we won't do anything.' It was actually giving that ownership to the people upfront... we were accountable to the people, not them to us. (Steering Group member)

What were some of the positive examples of evaluation practice?

Community support and acceptance for the program and evaluation is reflected through the ethics process, which required participants to consent to the evaluation. By seeking ethics clearance from Curtin University, the WA Aboriginal Health Ethics and Information Committee and Royal Perth Hospital Ethics Committee, evaluators were also better placed to share findings in academic journals as part of knowledge exchange activities.

Knowledge translation was central to the purpose of the evaluation, and the importance of providing feedback and dissemination of results was discussed:

It's important to provide that feedback and to gather information that you can provide feedback, but also write up articles to promote what we're doing. And then not just writing it up, but also being able to disseminate it to the right audiences and have it available for health professionals. (Evaluation team member)

The evaluation findings have been made publicly available with the full manuscript, 'Build It and They Will Come: Outcomes from a successful cardiac rehabilitation program at an Aboriginal Medical Service', published in 2013 in the *Australian Health Review* (Dimer et al. 2013). Findings for the project are also available, with the abstract of a conference presentation published in an academic journal and a summary published for another conference presentation.

In addition to contributing to the wider evidence base, the fact that Heart Health is a permanent program has meant that the evaluation was able to inform and refine future program delivery. This is not always the case with short-term funded programs. For example, one member discussed how the focus of the program shifted:

I guess the changes were that it switched to a chronic disease program, because that came out quite strongly, that people didn't just have heart issues. They were multi-varied. (Project team member)

Within the Heart Health evaluation, Aboriginal principles have largely been integrated into the evaluation as a result of great program design. The program itself was centred around Aboriginal ways of doing, including education through yarning and pictorial and informal learning to promote positive behaviour change; Aboriginal staff involvement in delivering the program; collective involvement of community members rather than individuals; and placement within an Aboriginal Medical Service to create a culturally safe environment and allow local ownership by the DYHS Aboriginal community. These principles were therefore also reflected in the evaluation practice.

Where are some areas where evaluation practice can be strengthened?

Despite programs such as Heart Health strongly reflecting the principles of cultural respect, holism and capacity building, such components are not always easily measured through classical evaluation frameworks that dominate the academic literature. The complete benefits of community-led health promotion activities cannot always be fully measured using classic biomedical evaluation (Rowley et al. 2015). In interviews, the Steering Group members spoke widely about the benefits of the program, including improved self-esteem, improved confidence, peer networking and community development, yet the focus of the peer-reviewed evaluation largely captures quantitative improvements to cardiometabolic profiles. However, it was mentioned that interviews, questionnaires and yarning sessions were included as part of the evaluation strategy to allow some of the social impacts to be better contextualised and understood. One member of the Steering Group added that they were in the process of doing follow-up work using participatory methods, such as photo-voice, to attempt to capture the social benefits of the program for participants.

Conclusions

The Heart Health evaluation provides an excellent case study through the strong integration of the Aboriginal research principles of community engagement, partnership, accountability, capacity building and governance. This case study also highlights that evaluation frameworks need to be strengthened so the full benefits of Aboriginal health programs can be measured.

Returning Home, Back to Community from Custodial Care pilot program, Muru Marri Indigenous Health Unit, University of NSW

- The Returning Home, Back to Community from Custodial Care pilot project was funded by Australian Government Department of Health and Ageing to provide support to Aboriginal and Torres Strait Islander women in prisons prior to and after release in three sites across Australia.
- The aim of the evaluation was to better understand appropriate and effective models of care to support Aboriginal and Torres Strait Islander women returning to community from custodial care.
- The evaluation strongly integrated culturally informed methodology, engagement and partnership with key stakeholders, Aboriginal participation in data interpretation, and knowledge-exchanging between the sites and stakeholders.
- The limited program development and implementation timeframe, limited resourcing and lack of approval of release of the report by the funder potentially led to lost opportunities for greater program success and wider learnings from the findings.

The evaluation of the Returning Home, Back to Community from Custodial Care (hereafter, Returning Home) pilot project was conducted between November 2013 and August 2014 by the Muru Marri Indigenous Health Unit in the School of Public Health and Community Medicine at UNSW. The project was funded by the Australian Government to provide support to Aboriginal and Torres Strait Islander women in prisons prior to and after release in three sites across Australia. The evaluation was designed to better understand appropriate and effective models of care to support Aboriginal and Torres Strait Islander women returning to community from custodial care.

Muru Marri was an Aboriginal-led academic unit with teaching, research and university service roles at UNSW. It privileged Aboriginal understandings of health, drawing upon Aboriginal experiences and knowledge systems. Muru Marri had an overarching commitment to comprehensive inter-sectoral collaborations, which are 'based on respectful, transparent partnerships: where all partners have the capacity to work competently across cultural divides [and which] offer the best hope of developing the "many paths" necessary to improve multifaceted Aboriginal and Torres Strait Islander health' (Arkles 2006:iii). In 2013, owing to its cultural and technical expertise across Aboriginal health evaluation, Muru Marri was approached and subcontracted to undertake the evaluation of Returning Home.

The evaluation was funded to engage with the three Returning Home pilot sites—an Aboriginal Medical Service in Western Sydney (New South Wales), the Townsville–Mackay Medicare Local in Townsville (Queensland) and the Goldfields–Midwest Medicare Local in Geraldton (Western Australia). As described by an evaluation team member, the aim of the evaluation focused on identifying 'what [we can] learn in different sites that will allow you to better support women returning back to the community from custodial care'.

In an interview for this case study, members of the evaluation team spoke of how Returning Home was designed to work collaboratively and account for diversity across the three sites. The evaluation used a purposefully designed Aboriginal evaluation framework, Ngaa-bi-nya, centred around Aboriginal worldviews, realities, and understandings of health and wellbeing. The Ngaa-bi-nya framework is an evolving framework, which was culturally adapted from Stufflebeam's (2003) Context, Input, Produces and Processes (CIPP) model. It aligns with and modifies an existing set of critical success factors developed by Muru Marri (Haswell et al. 2013). Within this framework, the evaluation team adopted a structured approach (at each site, considering the individual, program and system level) and used Aboriginal-informed evidence-based tools, including the Growth and Empowerment Measure or GEM, to guide discussions and interviews (Haswell et al. 2010).

What are the key ethical principles demonstrated by the evaluation?

The Ngaa-bi-nya evaluation framework was used to assess how the three models of care integrated features such as holism, responsibility, cultural leadership, strengths based, strong relationships, community capacity building, building infrastructure, progressive, spirit, workforce development, evidence based and addressing determinants of health. These features are well recognised within successful culturally sensitive models of care for Aboriginal people but are not always evaluated.

What were some of the positive examples of evaluation practice?

Engagement and partnership with key stakeholders, as well as knowledge-exchange between evaluation sites and stakeholders, were highlighted as key to evaluation success:

[We had a] good emphasis on communicating. That's probably one difference to other evaluations, [it] was not only to keep us connected, but to connect each different program. Out of respect that they were diverse, and to cross-fertilise and celebrate. That real strong principle of celebrating this work along the way that was tailored to the communities. (Evaluation team member)

A feature of this evaluation was that it was done alongside the program implementation. The evaluation was ongoing across the program and this allowed the community and evaluators the flexibility to influence and shape the direction of the program. It was noted that the evaluation:

Was part of the program. As we did and as we reflected, and we fed back, and we had discussions, and we asked people questions. That all influenced what they were doing so that we could do our reports. It was a constant cycle of sharing information in that kind of space. **(Evaluation team member)**

In this way, the evaluation served not only to improve the program itself but was part of a larger cycle of evidence-based practice:

The way you get the continuity, and the way you build on the evaluation knowledge, is every time we do an evaluation, we take the knowledge we've learned in that evaluation to the next evaluation, and we share it with people who are doing [other] programs. **(Evaluation team member)**

With regards to evaluation process, the limiting timeframes for the pilot evaluation meant that ethics clearance was unable to be obtained. Despite this, evaluators spoke of a personal ethic of working respectfully with Aboriginal people and communities. One team member spoke of a personal accountability to the Aboriginal community to do evaluation that was in line with Aboriginal communities' ways of doing:

As researchers... it's not a real separateness... it's about embracing our position, and understanding what influences our position. Hence having our principles sorted out that we're informed by. They roll off our tongue, because they are real to us. **(Evaluation team member)**

This ethic of working respectfully with Aboriginal communities also extended to appreciating and valuing Aboriginal knowledges and ownership of those knowledges. One member of the evaluation team spoke of the collaborative approach underpinning the evaluation:

We are here to harvest the learnings that you're sharing with us, but we're not owning those learnings... [Participants were] finding out, they were asking questions, trying things, so it was a sharing of that experience. **(Evaluation team member)**

Another member of the evaluation team discussed the collaborative approach to data interpretation that allowed Aboriginal voices to be heard, listened to and acted upon. Aboriginal participation and involvement was strong across the project, with Aboriginal evaluators and service providers instrumental in the evaluation design, data collection and writing. An evaluator discussed the role of service providers and how their participation in the evaluation extended beyond being subjects of research:

We gave [service providers] the summary of the data. That is very much co-authored, so if you look at each of those, you will see that there are names of the participants at both sites, and then it was all rolled up into this. So we were very conscious that it was their data that we were given a chance to work with and pull together, and then get feedback. **(Evaluation team member)**

Where are some areas where evaluation practice can be strengthened?

The program was characterised by very short development and implementation timelines, as well as limited resourcing. This in turn translated into lost opportunities for greater program success and also prevented the evaluation from being able to obtain ethics approval.

Some limitations with regards to knowledge translation processes following the report were highlighted by evaluators. Although results were disseminated to communities, the lack of approval for the report release by the funder meant that people and organisations outside government and the communities involved were unable to learn from the findings.

Conclusions

Overall, the evaluation of Returning Home provided insights into culturally informed and respectful methods, collaboration, use of the Ngaa-bi-nya framework concurrent to program delivery and ethical practices, and eliciting critical success factors in a model of service including program and system-level factors. Members of the evaluation team highlighted the importance of utilising a variety of context-appropriate qualitative and quantitative methods, as well as the need to work towards consistency in what is measured in evaluation, through standardisation of measurable criteria and evidence-based measures in evaluations; this would assist programs to reach their full potential and communicate their needs to program funders and implementers. While the evaluation was positioned to contribute to the evidence base available for future program design and policy, this aim was unable to be achieved due to the funder decision not to release the evaluation report. This calls into question the utility of the resources invested in the evaluation, as well as the pilot project itself.

Sentinel Sites Evaluation of the Indigenous Chronic Disease Package 2010–2014, Menzies School of Health Research and The University of Melbourne

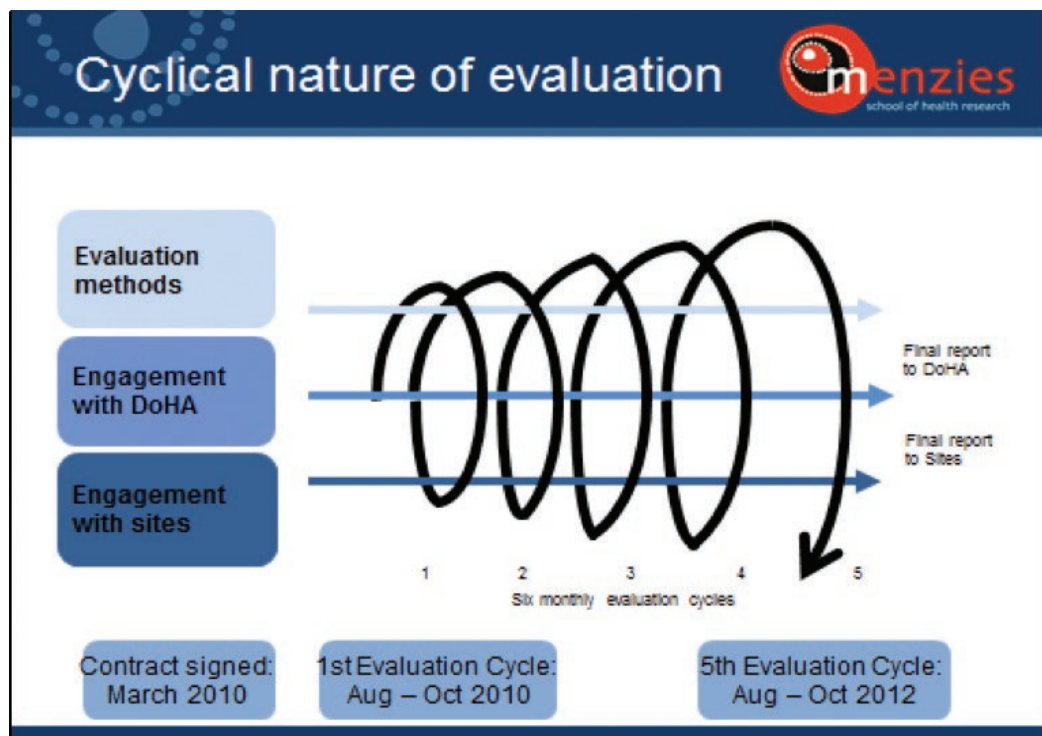
- The Australian Government’s Indigenous Chronic Disease Package (ICDP) commenced in 2009 and is an ongoing commitment of around \$260 million per annum across three priority areas: tackling chronic disease risk factors; earlier detection, improved management and follow-up of chronic disease in primary health care; and expansion of the Aboriginal and Torres Strait Islander workforce and increased capacity of the health workforce to deliver effective care.
- The Sentinel Sites Evaluation (SSE) was a place-based monitoring and formative evaluation designed to provide feedback to government and stakeholders on progress, barriers and enablers to successful implementation. The evaluation involved 24 sentinel sites across Australia
- Iterative cycles of data collection, feedback and response provided Aboriginal and Torres Strait Islander communities with a voice, contributed to ongoing program refinement and improvement, and highlighted the influence of local context on program rollout (see Figure 18).
- Program data used as part of the SSE could have been strengthened through greater orientation to community needs and additional support.

- Enhanced opportunities for learning between sites would have also strengthened the SSE.

The SSE was commissioned by the Australian Government through competitive tender. The scope of services asked the SSE team to conduct a formative evaluation of early implementation of a multi-component program—the ICDP—which was managed through seven divisions of the Australian Government Department of Health and implemented through several service delivery channels (including private and community-controlled primary health care services, community organisations, local and regional organisations such as Aboriginal community-controlled peak bodies and Medicare Locals), and supported by incentives and workforce initiatives. The evaluation was to be guided by previously developed linear matrix program logics, which used a log frame approach setting out inputs, early results and longer-term results for each of the 11 program areas, as well as a high-level set of intended results and activities for the package as a whole. Detailed methodology and findings are outlined in the SSE final report (Bailie et al. 2013).

The evaluation included 24 sentinel sites across Australia with varying degrees of intensity of data collection and analysis. Administrative and program data were collected and analysed for all 24 sites and 16 of the sites also involved the collection of clinical indicator data and key informant interviews. Eight sites (called ‘case study sites’) included community focus groups.

Figure 18: Cyclical nature of the Sentinel Sites Evaluation



What are the key ethical principles demonstrated by the evaluation?

The SSE was guided by the ethical principles outlined in the National Aboriginal and Torres Strait Islander Health Data Principles, endorsed by the October 2006 Australian Health Ministers' Advisory Council meeting (Department of Health and Ageing 2007), the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health, 2004–2009* (AHMAC Standing Committee on Aboriginal and Torres Strait Islander Health Working Party 2004) and the NHMRC *Values and Ethics* guidelines (NHMRC 2003). Ethics approvals were sought and granted through the Department of Health Ethics Committee, project 10/2012.

Early consultation and negotiation at each site was a key component of the ethical conduct of the evaluation. The team developed a plain language brochure informing the community about the evaluation. The brochure ensured people received consistent information about the SSE across the sites and could see that the evaluation was being conducted in an ethical way. It presented information that could be discussed before people were asked to sign informed consent forms, was a take-home resource for people to share information with others, and made it easy for participants to contact the evaluators if they had questions. Visual agendas for focus group discussions helped to ensure inclusivity.

What were some of the positive examples of evaluation practice?

Improving access to high-quality primary health care for Indigenous peoples is critical to closing the gap in health outcomes. Through its focus on informing improvements to a large-scale national investment in prevention and management of chronic disease, the SSE had a role in policy and program change to better address needs of Aboriginal and Torres Strait Islander communities. The approach of the evaluation, focusing on how the ICDP was working at the local level and how different components of the package worked (or failed to work) together and with other potentially complementary initiatives, highlighted areas in which program adjustments and flexibility in policy interpretation were required to better meet the needs of local communities and enable service providers to provide co-ordinated services. This approach had various benefits, as shown in the quotes below:

The use of a sentinel approach [focused] scarce evaluation resources in a project that would otherwise have been too large to do in-depth evaluation. Having three different patterns of data collection, depending on the site, was also a creative approach. (General Practitioner (GP) program implementer)

I think the value of having a local perspective and local lens to really understand how well our programs are working. We have a very high-level program perspective and the Sentinel sites just showed, well that's not how things work on the ground, it's a lot of complexity that programs need to work in. And people don't necessarily see or understand the difference between discrete government programs, it's just... They see the whole mixture of things and the system they need to navigate to access the services and care they need and the various issues and challenges associated with that. (Evaluation commissioner)

It put a real lens on capacity issues, organisational capacity issues, by highlighting the local variation between sites and just how important capacity and that systems perspective was to determine how well sites were able to implement the package and ensure it complemented their other services and programs for better outcomes. (Evaluation commissioner)

Rather than gathering dust on [the] shelf or being ignored in a hard drive, the data gathered was actually used to improve the program at a local level, as well as to measure its success. (GP program implementer)

High-quality and effective practice in evaluation in Indigenous community settings includes elements of flexibility, community control and ownership, and inclusiveness, along with the more generally applicable standards of rigour that apply to all evaluations. Data collection visits were scheduled to fit around what worked for the local workers and community events. Often, planned visits had to be rescheduled due to unforeseen circumstances, such as a death in the community, and the continued engagement of sites attests to the professionalism of the SSE team. Local Aboriginal Health Services and Medicare Locals helped to arrange community focus group discussions and interviews following local protocols. People in local ICDP-funded positions confirmed dates and organised the focus groups—how they were publicised, who was invited to attend, venue and transport. These were often held in Aboriginal Health Services and community venues. There was a consistent organising approach across the case study sites, with organisation of the focus groups in local community hands. The SSE team developed 'illustrated agendas' to guide community focus group discussions—these enabled people with varying levels of literacy to be informed about what the group was going to be talking about and helped to keep the conversations on track. An Indigenous project officer discussed how this approach worked in her community:

I think the timeframes were positive and well thought out, and they gave us time to establish the focus groups and get the information required in a timely manner, without causing extra angst on us as workers. I think the community being involved from the ground [providing a voice in focus groups] was very positive because you can't talk for everybody. So, it gave everybody a choice to be part of that group. I couldn't find any fault in the model or the process. The team were constantly in contact with us and following up to see how things were or if we needed any extra help or if there were things they could support us with as part of the evaluation sites. Those were all the things that I think [were] done well. **(Aboriginal and Torres Strait Islander program implementer)**

In each iteration of data collection and reporting, the SSE team explained what had happened with the information people had shared, so it was clear that community voices and stories were respected and valued, that people had something important to say and were heard, and their stories contributed to some changes in the way the ICDP was being rolled out. The following quotes illustrate this engagement from the perspectives of the Aboriginal and Torres Strait Islander community members, the SSE team and program implementers:

We know about government services that come and talk to us to tick their boxes, but you have not done that. You have come to hear from us how the program is working for us, and taking that story back to the powers that be to improve the program and services we are getting through that funding. **(Aboriginal and Torres Strait Islander community member)**

We would recognise people from previous community visits and remember their names—and we could build on their stories, and asked what had changed since the last visit. This giving back was important—it showed we were there to help and answer questions as well as take away stories. (Evaluator)

It was a very, very positive program out there for our community if it is implemented well. When you are involved with community they take ownership. When things don't go well. It's not like they are blaming, it's about OK, how can we do this better? (Indigenous project officer, program implementer)

The SSE team sought to ensure that the meaning of data collected during the site visits was not lost when it was fed up the line. Full team analysis workshops at the end of each data collection cycle, in which fieldworkers came together with the co-ordinators and evaluation lead and explained the context of the data, clarified stories and discussed their meaning. The workshops supported interpretation, and compared and contrasted findings in the different sites. The SSE team also met with program managers within the relevant divisions of the Department of Health to provide early feedback on findings and discuss implications for refining the design of the ICDP as the evaluation progressed. These processes also enabled the key issues of focus for the following cycle of evaluation to be identified.

The SSE drew on evaluation theory combining a utilisation-focused approach with realist evaluation methodology. In its focus on the usefulness of the evaluation to stakeholders, and for program improvement, the SSE place-based evaluation bears some resemblance to the developmental evaluation approach, which reflects a meta approach that brings evaluative thinking into real-time design of programs, and recognises that even large-scale programs seldom arrive 'fully formed' and ready for roll out, but tend to be adapted along the way in response to local contextual factors, political realities and emerging information.

The successful conduct of this large-scale, long-term evaluation and the sustained engagement built over time with Indigenous organisations is likely to have helped to build capacity for evaluation and an interest in its potential to improve outcomes for Indigenous people. This is illustrated in the quote below:

The aspects I most appreciated in this evaluation were the engagement with individuals and organisations and the evidence of a thorough, culturally sensitive and professional evaluation and a useful, well presented and high-quality report. In my work roles I found it to be both practical and empowering. I believe it provided an exceptionally clear and useful evaluation of a complex area. The methodology, including a participatory approach and inclusion of Aboriginal and Torres Strait Islander people on the research team, was appropriate and effective in ensuring a meaningful evaluation was undertaken. **(GP, program implementer)**

Where are some areas where evaluation practice can be strengthened?

Challenges were encountered at various stages and drew on the different resources of the SSE team. There were practical challenges at the outset in defining sites—sites could not be defined in abstract terms, but needed to be built up iteratively, drawing on local knowledge of patterns of primary health care service use and the location of key service providers for the Indigenous population and then mapping against Statistical Local Areas/postcode boundaries.

Program monitoring data were weaker than expected, and data for the different programs were not always able to be obtained in a way that corresponded to consistent geographic or administrative boundaries. In early evaluation cycles, there was very little program activity to report (since the program was in an early stage of implementation). This caused some frustration to program managers within the commissioning department, who wanted to see evidence of program rollout and had not appreciated the time needed between resource allocation and evidence of program implementation on the ground.

The process of reporting back to Aboriginal and Torres Strait Islander communities was a critical part of the evaluation. Moreover, there was limited opportunity for sharing learnings between sites. The need for further innovation in this area was emphasised by an evaluation commissioner:

We really want to get much better at how we communicate the findings of evaluations to different stakeholder groups at different levels of the system... So rather than just thinking about it at the end of the evaluation, really think... how do we share and disseminate those findings as we go. And really interactive ways to distribute findings to the players at different levels of the system. And encourage that learning between different local sites as well as regional learning and so on and national learning to really drive change. It would be fantastic to have a much clearer link between the evidence and evaluation and improvement in the system.

Conclusions

Over the course of the SSE, the team conducted and analysed more than 700 in-depth interviews with service providers and 72 focus groups with 670 Indigenous community members. Forty-one health services contributed clinical indicator data and the commissioner provided administrative data from program rollout, the Australian Medicare and Pharmaceutical Benefits Schemes, and the Practice Incentives Program—Indigenous Health Incentives scheme. The SSE demonstrates how high-level policy imperatives can be reconciled with providing benefit to Aboriginal and Torres Strait Islander communities. The impacts of this on informing future evaluation practice are illustrated by an evaluation commissioner:

The learning from this evaluation and other pieces of work [have] formed our current thinking about evaluation and we're very lucky to have the opportunity to, at the moment, have a much more strategic approach to evaluation, where we're exploring cross-cutting themes and also involving stakeholders in the actual design of the evaluation as well as the implementation. So that includes local Aboriginal people and communities as well as other stakeholders in that, so that's very exciting.

Stronger Communities for Children program, Ipsos and Winangali

- The Stronger Communities for Children (SCfC) project is a community development program aimed at building stronger and safer communities across ten remote locations in the Northern Territory.
- The SCfC project was evaluated by Ipsos and Winangali, which is an Aboriginal community consultancy organisation that engaged with Aboriginal communities across the sites.
- Central to the evaluation was Aboriginal involvement (including ethics and data ownership), evaluation co-design with communities, accountability of the evaluators to community, community control and governance, partnerships and community engagement, and knowledge exchange and feedback processes.
- The SCfC evaluation highlights ways in which the knowledge and voice of Aboriginal communities can be incorporated in projects and evaluation and how evaluators and commissioners can engage with communities to share evaluation knowledge.

The SCfC project arose out of the Stronger Futures in the Northern Territory Agreement between the Australian and Northern Territory governments and aimed to build stronger and safer communities across ten remote locations in the Northern Territory. The community development project was initially funded by the Department of the Prime Minister and Cabinet to be undertaken across five sites in 2013 (Galiwin'ku, Ntaria, Ltyentye Apurte, Wadeye and Ngukurr), with another five sites signing onto the project in 2015 (Gunbalanya, Maningrida, Atitjere, Lajamanu, Utopia homelands).

The project entails pairing each of the ten Aboriginal communities with a facilitating partner to deliver services that will support local children and families to be strong, safe and healthy. A evaluation commissioner described this process:

So the department funds the facilitating partner, an organisation, ideally Indigenous... who then works to establish a local community board. It could be an existing leadership group in the community or it could be a new body that was established as part of this program. And what's really important about that group is that the board need to have cultural authority in their community to make this program work. And they really are a decision-making body about how the funding that we give to that community is then spent.

What are the key ethical principles demonstrated by the evaluation?

Developed in a wider policy environment committed to closing the gap in Aboriginal outcomes, the project is underpinned by an equity approach. This evaluation was developed using a co-design process with a larger organisation, Ninti One, working with communities to develop their own impact assessments. The evaluation approach was guided by four principles to ensure that Aboriginal boards and facilitating partners were able to engage not just in data collection but knowledge exchange more generally:

- impact assessments need to be easy for non-specialists to understand
- data systems need to be simple yet sophisticated
- impact assessments need to produce useful information to help make decisions
- data should foster community ownership.

Both Aboriginal self-determination and community control are key principles of the program. The Aboriginal boards are the governing bodies that provide a collective voice advocating on behalf of the whole community. Within the SCfC project, they work closely with facilitating partners to allocate resources and implement service delivery. Through the project, Aboriginal communities identify their own strengths and develop or continue to fund regionally specific services. The boards also provided advice on the development of the evaluation in their communities.

What were some of the positive examples of evaluation practice?

Selection criteria for the evaluation tender included the specific requirement that prospective evaluators 'must have experience conducting research with remote Indigenous communities, preferably with current connections with communities selected for the final sample'. This criterion required prospective evaluators to be accountable to Aboriginal communities, not just to commissioners of research.

Evaluators Ipsos, together with Winangali, were successful in the tender process. In November 2016, Winangali, an Aboriginal community consultancy organisation, led engagement with Aboriginal communities across the sites and together with the Ipsos evaluators conducted further in-depth analysis in three communities. An evaluation commissioner spoke of the benefit of having an Aboriginal organisation involved to provide cultural advice and brokerage:

Winangali, that's an Aboriginal registered company who we actually contracted with. And then they employ people, Aboriginal people, to go into the communities to do the more in-depth work in the communities.

The evaluation also made particular use of the *Knowledge and Intellectual Property Protocol* developed by Ninti One (Dixon et al. 2009) to help communities navigate issues such as ethics, confidentiality, knowledge dissemination, mutual benefit and ownership of Aboriginal knowledge. These protocols guided the evaluation and ethical approval was obtained.

Many of the principles from the program were carried through to the evaluation, particularly partnerships and engagement. A commissioner reflected on how partnership and meaningful engagement with Aboriginal communities was central to the evaluation process:

This program was very much about partnerships with the communities. So we tried to conduct the evaluation in a way that is in keeping with the philosophy of the whole program of working together. **(Evaluation commissioner)**

The evaluation was designed to complement evidence-generation and knowledge sharing activities that were embedded in the program. Incorporating the evidence from the program activities and knowledge sharing within the program meant that community members were aware of the evaluation process from an early stage:

It was about that embeddedness of the evaluation into what people were doing anyway. It wasn't about trying to add extra. It would be like, well, people are having meetings talking about activities they want to progress in their work plan. Doing their thing. Then the evaluation is part of that conversation. And, about people wanting to be involved. There were a lot of people, they had really good numbers of community people who wanted to talk to the evaluators about the program. **(Evaluation commissioner)**

To facilitate engagement with families and the wider community, the evaluation used methods such as focus groups and open-ended interviews that would allow for community voices in the research. These methods were part of a broader action research learning approach.

As a part of knowledge exchange activities, evaluators provided communities with comprehensive reports that were owned by the community:

The evaluators did quite detailed reports for each of the communities that participated in the feedback, but those will be owned by the community. That's not about us publishing those findings. There is that issue of recognising confidentiality and all those kinds of things as well. So making sure that participating communities receive high-quality feedback as a result of their involvement. **(Evaluation commissioner)**

In addition, Ninti One provided communities with a plain language two-page summary of key evaluation findings for their communities. This plain language format meant that information was usable by boards and facilitating partners. In addition, findings from the evaluation were shared with the ten communities as part of a Knowledge Sharing Seminar. These workshops provided the communities with opportunity to respond to and contextualise the findings, as well as learn from and share with other communities. The communities themselves were able to share their learnings from their regions with the Department of the Prime Minister and Cabinet, as one evaluation commissioner noted:

Some of the community members came in and presented to people within the department. So from the communities they came and talked about what they're doing and incorporated the evaluation findings as part of that. And we do plan to have further sessions with other agencies to disseminate the learning. So essentially it's trying to share the learnings around place-based work which everyone... a lot of people are trying to do more of, especially in the remote context.

Where are some areas where evaluation practice can be strengthened?

Evaluation commissioners noted complexities in obtaining clearance for an evaluation that was not seen as classical research. The ethics process was complicated by the fact that ethics committees and ethics processes have traditionally been established to review research rather than program evaluations.

So there was the Central Australian body and one for the northern bit, which was Menzies. We had problems with that because it wasn't... Because it was evaluation as opposed to research, there just seemed to be a lot of confusion from the ethics approving bodies about what's this really trying to do. **(Evaluation commissioner)**

In the SCfC evaluation, developmental-based methodologies were used with conversational approaches as opposed to highly structured qualitative methods, which made for a complex ethics review process:

While we had broad evaluation questions that we wanted to explore, we didn't have a highly structured, straight out interview schedule... [ours was] unstructured because it needed to be driven by the community researchers attuning the questions by interpreting what we want to find out from the evaluation questions and for them to be able to develop appropriate questions to ask, in the context of the community. I think that this particular ethics committee were uncomfortable with the fact that we couldn't say, 'This is the exact questions that we're going to ask'... I think that they just had this view that the evaluation was about this process. It was outside a research arm perspective only. Rather than the embeddedness. (Evaluation commissioner)

Conclusions

Overall, this evaluation demonstrates many of the principles of partnerships, community control, strengths-based approaches, holism, strengthening capacity and skills, and partnership. The integration of these principles into evaluation has been possible through undertaking evaluation planning alongside good program design. In this way, the SCfC project highlights ways in which the knowledge and voice of Aboriginal communities can be incorporated in projects and evaluation and how evaluators and commissioners can engage with communities to share knowledge. The experience of the evaluators in engaging with ethics committees illustrates the need for evaluation principles to be more clearly understood in relation to ethical Aboriginal and Torres Strait Islander health research.

Two Gathering Places in the Eastern Metropolitan Region of Melbourne, *Onemda Koori Health Unit, The University of Melbourne*

- Gathering places are community hubs that are driven and controlled by the community. They are initiated by local Aboriginal communities and change in accordance to the needs of each local community.
- The purpose of the evaluation was to document the achievements and opportunities of the gathering place model in improving health and wellbeing outcomes of Aboriginal communities in Victoria.
- Embedded in the evaluation were accountability of evaluators, commitment to Aboriginal research ethics, Aboriginal governance (project reference groups), focus on the holistic nature of Aboriginal health and wellbeing, partnership and community engagement (participatory research).
- Following completion of the project, a 12-month embargo by the funder constrained the evaluators in disseminating key findings and learnings from the evaluation.

Gathering places are spaces that have evolved in accordance to the needs of each local community. One evaluation team member said, 'They have been developed for that particular community and in partnership with that particular Mob, by the local Mob.' As such, each gathering place is unique and has its own history, way of working and services that they provide. However, all are underpinned by a similar philosophy—that positive health and wellbeing is promoted through the existence of cultural places that connect and heal Aboriginal communities.

What are the key ethical principles demonstrated by the evaluation?

A commitment to Aboriginal research principles underpinned the evaluation approach with ethics and community engagement processes considered comprehensively. Ethical approval was obtained through The University of Melbourne Human Ethics Advisory Group and the Human Ethics Subcommittee and the overarching project was guided by the NHMRC *Values and Ethics* guidelines (NHMRC 2003), while local representative bodies were also set up at the gathering places so that the evaluation could be responsive to local community protocols.

Really it was built on the NHMRC Ethics and Values guidelines. But also, some of our past work at Onemda... Onemda principles were really embedded in the evaluation. Onemda principles were strong on community development and self-determination... Engagement. Proper engagement. Feeding back and getting the communities' input on that part of the project as well. As well as opportunities to be involved in the reporting process. So they were probably the pillars... We probably didn't have to go to that length. But it was something that we decided as a team would strengthen the project and the outcomes for the community. **(Evaluation team member)**

This commitment to ethical and process-driven evaluation went beyond what is generally expected in government-commissioned evaluation and reflects the personal ethic of evaluators to do both ethical and culturally respectful research. For the evaluators, getting ethics clearance and putting processes in place took time but was seen as important to demonstrate accountability to Aboriginal communities.

So I think that when we talk about those guidelines [NHMRC] we did them to the absolute, I think got as close to, in my opinion, a perfect model of engagement as you can... So where as you look at some [other] evaluations... they didn't have any Ethics... They had maybe an advisory group. I think there was a bit of an imbalance between those evaluations and this. **(Evaluation team member)**

Several Aboriginal research principles underpinned the approach taken by evaluators:

So we had self-determination, respect for cultural knowledge, strong governance, advocacy, flexible approach, pathways to other organisations, capacity building, holistic health models and sustainability. Also, we had within that the enablers of those principle[s] such as place, programs, community and people and history was part of that also... Context and the history of place and people to place was really important in the way we evaluated and measured outcomes as well. **(Evaluation team member)**

The evaluation demonstrates good evaluation as it is one of the few evaluations that really captures Aboriginal health and wellbeing as understood and recognised by Aboriginal communities. Key evaluation questions sought to capture the holistic nature of Aboriginal health, with evaluators broadly aiming to identify the health and wellbeing benefits of gathering places, how they facilitate access to health, document their programs and understand factors facilitating sustainability. Through qualitative interviews, the evaluators were able to move away from physical concepts of health and really get a more comprehensive picture of the impact gathering places were having:

What they were currently measuring before we got there were very clinical based measures of health, without consideration of wellbeing. It was very quantitative focused and didn't really engage with the things that were happening in gathering places... we did measure these things through the conversations we had with people. Health and wellbeing things. Inclusion. Empowerment. Connection. **(Evaluation team member)**

What were some of the positive examples of evaluation practice?

The tender request by the Victorian Department of Health and Human Services had a strong focus on accountability, with the inclusion of three criteria that required evaluators to demonstrate both ability and commitment to working respectfully with Aboriginal communities. These criteria go beyond the usual tender criteria that request evaluators to demonstrate their understandings, experience, resources and commitment to evaluations more generally:

- The proposal demonstrates a valid and effective approach to the delivery of the outcomes and outputs specified, which is both technically and culturally appropriate;
- The key personnel who will be undertaking the project can demonstrate experience of conducting research and/or evaluations with Victorian Communities; and
- The bidder demonstrates recent work experience and existing relationships within Victorian Aboriginal communities sufficient to conduct the project as specified.

The successful evaluation team comprised three researchers, two of whom were Aboriginal. The team members each had several years of experience working in Aboriginal research and a history of working with Aboriginal organisations and communities. The evaluation team was based at the *Onemda* Koori Health Unit at The University of Melbourne, a research unit that is recognised nationally for its Aboriginal leadership and approach to Aboriginal health research.

Aboriginal involvement and engagement was central to how the evaluation was conducted. As gathering places are spaces of strong Aboriginal organisation and leadership, the evaluators saw it as important to engage with leaders in respectful ways:

I think the leadership from key people in the community is very important. Because that supports other people to engage and so getting those key people to be part of the project is a big factor in how you engage with community. **(Evaluation team member)**

Establishing reference groups was key to ensuring that there was a channel to engage with Aboriginal communities involved in gathering places.

That was one of the first things we did. We contacted each gathering place and asked them to be on a reference group to actually provide advice and talk through the project as we went. **(Evaluation team member)**

The engagement strategy was highly participatory, with local gathering places involved in analysing, making sense of and validating the findings. This was largely facilitated through community involvement in a data indicators workshop, co-design in interview schedules and a data analysis workshop, as well as back-and-forth emailing and review of reports. These engagement activities also formed part of the knowledge translation activities:

We used an iterative process of data collection. We kept debating, and it was a frustrating time for all of us. But, the narrative that we created was created by us fighting over codes and then going back to community and there was consultation. But, it was more than just consultation, it was actually that the data was shaped by discussion. I am not even sure how you interpret that. It wasn't just the evaluator writing it. There [are] a lot of voices in the data, it is not just one or two people doing it... and I think that in a lot of projects you don't get down to that critique. I don't think other evaluation ever questioned some of the [logic] models. **(Evaluation team member)**

Where are some areas where evaluation practice can be strengthened?

In reflecting on their engagement strategy, the evaluators acknowledged that the burden of full participation in evaluation is huge for communities whose core business is the work they do for their community, and called for more resourcing to strengthen community capacity to fully engage in evaluations:

the level of commitment for a community, where the benefits aren't clear and it isn't really an immediate impact on their organisation or their job [means that it] is really difficult to stay engaged and committed. So you can really... overstep the mark quite easily expecting people to turn up for [a] reference group, for a workshop, for an interview to give feedback. So I think for evaluations and research in general we do need to think how that capacity is resourced better. It's not built into projects, it's not built into funding applications. There is just an expectation that the community will participate because it's for the greater good. **(Evaluation team member)**

As for knowledge exchange, an evaluation summary and report were prepared for community and government. However, this report was only made publicly available a year after it was submitted, owing to departmental embargos. The evaluators are currently in the process of working with gathering places to further disseminate key findings and learnings from the evaluation.

We are talking about publications conferences. We really want to engage the gathering places in that. So we don't see that as finished. Yeah, I think involving gathering places as part of that could be a really good outcome just for them to be able to reference that in the future around how they have been talking about their impact. **(Evaluation team member)**

However, owing to the short-term nature of evaluation work, the evaluators have moved into new roles and their capacity to produce publications and present findings at conference is limited. Publications were only proceeding as evaluators feel an accountability to the gathering places to share the evaluation findings.

Conclusions

Overall, the strengths of the gathering place evaluation include a tender process that made evaluators accountable to doing good and culturally respectful evaluation, strong Aboriginal leadership, strong engagement and participation, and a strong commitment by evaluators above and beyond expectations to do ethical and culturally respectful research. This evaluation is also a good example of what to evaluate as it employed a framework where health was understood using Aboriginal concepts of health and wellbeing. These successes were largely owing to the experience and skills of evaluators, whose experience doing Aboriginal research was facilitated through places such as *Onemda*. The high level of commitment required from Aboriginal and Torres Strait Islander communities and organisations to participate in research, including evaluation, highlights the need to balance community engagement with consideration of ways to minimise participatory burden for communities. This may entail more resourcing to enable fuller community and organisational participation.

Case studies conclusions

Taken together, the case studies serve to demonstrate concrete ways that ethical practice in evaluation of Aboriginal and Torres Strait Islander health programs are currently being carried out, as well as indicating directions for improvements in future practice. A key feature of the case studies is how the ethical principles are intertwined. In the Gathering Places evaluation, tender criteria that select for evaluators who emphasised partnerships and accountability led to contracting with evaluators who strongly incorporated Aboriginal engagement and community involvement at all stages. The simultaneous design of programs and evaluations in the Heart Health and ESP programs was associated with greater stakeholder involvement and evaluations that reflected the program principles.

Systems-level challenges were experienced in several case study sites. Funder decisions impacted dissemination of evaluation findings, while tight timelines limited the possibility of learning and sharing within the program cycle. Several case studies also demonstrate some of the difficulties encountered in trying to do things in a 'new' way—ethics committees that needed to be oriented to the ethics of evaluation practice or extended amounts of negotiation needed between evaluators, communities and stakeholders to bridge the different perspectives. The utilisation of a framework may assist in this process by making explicit the requirements for ethical evaluation practice.

5. Conclusion

The aim of this report is to identify ways to increase the benefits of the evaluation of health and wellbeing programs for Aboriginal and Torres Strait Islander people. Accordingly, project activities focused on identifying the extent to which past evaluations delivered benefit to Aboriginal and Torres Strait Islander communities and identifying promising strategies for improving benefit to Aboriginal and Torres Strait Islander people. The project did not seek to review the quality of evaluations from a methodological or technical perspective. Nonetheless, the project has provided important insights into the ability to bring together the evidence from evaluations.

The project reviewed all evaluations of programs addressing health and wellbeing among Aboriginal and Torres Strait Islander people where a request for tender was publicly advertised in the past ten years. Direct requests were made to tenders sites, relevant websites and databases, which were searched, and listed contacts were individually followed up. Only 5 per cent of tender documents and 33 per cent of evaluation reports were able to be obtained. This suggests that it is not currently possible to comprehensively review the evaluation of programs focusing on Aboriginal and Torres Strait Islander health and wellbeing. It is also not possible to accurately estimate the number of evaluations from the number of reports available. This in turn suggests that claims that 10 per cent or less of Aboriginal and Torres Strait Islander programs are evaluated may reflect a lack of public availability of reports rather than a lack of evaluation per se (Lokuge et al. 2017; Hudson 2017). Any review, including those conducted in this project, will be limited because of this lack of transparency. Recent initiatives to improve access to evaluations are welcome (PM&C 2017) but enabling access to past evaluation is required to enable consistent approaches to the use of evidence.

In terms of quality assurance, it is important that tender documents and the reports arising from them are available. If evaluations are not meeting expectations, then this could either be because those expectations are not clearly specified in tender documents or because expectations are not being met by evaluators despite being clearly specified. The original plan for the project was to link tender documents with evaluation reports in order to identify key points in the implementation of evaluations that need to be strengthened. Lack of availability of tender documentation and evaluation reports meant that this was not possible. Tender document specifications are a mechanism for ensuring that evaluations are high quality and that evaluations benefit Aboriginal and Torres Strait Islander people. It is important that they are considered when assessing how to improve the evaluation process.

In considering how to improve the benefit of evaluation for Aboriginal and Torres Strait Islander people, the project considered principles underpinning both what evaluations should address and how evaluations should be conducted. An evaluation framework (Parts A and B) was developed to support greater Aboriginal and Torres Strait Islander benefit in both areas.

Principles informing what to evaluate

Australian governments have developed principles for working with Aboriginal and Torres Strait Islander communities that should be reflected in programs and, in turn, evaluations. The principles are:

- holistic concept of health
- partnerships and shared responsibility
- cultural respect
- engagement
- capacity building
- equity
- accountability
- evidence based
- governance.

The review suggested that the integration of all principles could be improved. Reporting varied considerably between evaluations, so it was often difficult to tell if principles were absent because they were absent in the program or because they were absent in the evaluation. Better-integrated principles were those most consistent with government policy agenda. For example, equity was present in around half of all documents (tenders, 44%; evaluation reports, 57%; peer-reviewed literature, 51%). The need for an evidence-based approach was well integrated into tenders (77%) and the peer-reviewed literature (67%) but less well integrated into evaluation reports (33%). Holistic concept of health, which is a key principle for Aboriginal and Torres Strait Islander people, was poorly integrated (tenders, 17%; evaluation reports, 33%; peer-reviewed literature, 26%). Although partnership was often mentioned in evaluation reports (62%) and the peer-reviewed literature (73%), there was very little evidence of equal partnerships with Aboriginal and Torres Strait Islander people. Partnership did not feature strongly in tender documents (10%), perhaps suggesting an opportunity for greater leverage. Evaluations conducted by ACCHOs were normally better at incorporating these principles, suggesting a potential leadership role in this area.

Part A of the evaluation framework—which considers *what* to evaluate, with indicators for each principle—was developed to support better integration of the principles in evaluations of programs addressing the health and wellbeing of Aboriginal and Torres Strait Islander communities. The indicators were drawn from the reviewed evaluations and supplemented by the project team. The framework was refined through consultations and a project workshop. An additional principle was added, focusing on community strengths, following input from the workshop. Although all indicators may not be appropriate to all programs, they do provide a guide to the principles that should be considered in evaluations of Aboriginal and Torres Strait Islander programs.

Principles informing how to evaluate

The project identified critical areas that need to be addressed to improve the benefits of evaluation to Aboriginal and Torres Strait Islander people. Key themes included improved transparency around all aspects of evaluation and support for Aboriginal and Torres Strait Islander leadership in all phases and at all levels of the program planning and evaluation cycle. Developing a principle-driven approach to address these issues will require improving the application of existing ethical principles to evaluation and developing ethical frameworks that better fit the context of evaluation.

Existing evaluation frameworks in health are designed for investigator-driven research. Accordingly, the focus is on the relationship between the researcher and participants (both individual and community). Benatar and Singer (2000,) have proposed ‘a new, proactive research ethics concerned with reducing inequities in global health and achieving justice in health research and health care’ (pp825). This requires shifting the focus of ethics from issues that arise within the researcher-participant relationship to ensuring that benefits to health and research capacity reach communities, particularly those that are disadvantaged and marginalised. These new ethical frameworks for ensuring that research and evaluation deliver ‘health justice’ identify specific obligations for commissioners, evaluators and program implementers (Ruger 2009). Parties are assigned obligations because the functions they typically assume make them particularly capable of fulfilling the obligations (Pratt & Hyder 2015; CDC 2011). This approach expands upon but is not inconsistent with existing approaches to ethics in Aboriginal and Torres Strait Islander health (NHMRC 2003, 2010).

The project developed Part B of the evaluation framework—which considers *how* to evaluate—by adapting these ethical concepts to the evaluation of Aboriginal and Torres Strait Islander programs in health and wellbeing. Feedback from the workshop suggested that it was important that the framework was a point in the pathway towards better evaluation rather than an endpoint. Some aspects of the framework are already reflected in current practice. Other areas, such as incorporation of Aboriginal and Torres Strait Islander people in priority setting, particularly at higher policy levels, require further work. Knowledge translation post-evaluation remains an area that also requires further development. The enhanced performance framework under the *Public Governance, Performance and Accountability Act 2013* (Cth) highlights the need for greater accountability through evaluation (Department of Finance 2017). Providing a response to evaluations is a key component of accountability and will help make it clear to Aboriginal and Torres Strait Islander communities that the information they have provided has informed decision making and program development. There is also a need to strengthen application of ethics more generally. Ethics was mentioned in 72 per cent of tenders, 48 per cent of evaluations and 80 per cent of the peer-reviewed literature.

Key elements required to support and advance Aboriginal and Torres Strait Islander community-level engagement in relation to policy, programs and services evaluation

Programs in health and wellbeing are often multi-layered and complex, as are their evaluations. There is strong recognition that Aboriginal and Torres Strait Islander people need to be involved in program development and evaluation. However, this often consists of consultation rather than leadership roles. Where Aboriginal and Torres Strait Islander leadership is recognised, it is more likely to be at local levels of decision making, often when program parameters have already been defined. There are positive initiatives to include Aboriginal and Torres Strait Islander people in the co-design of higher-level evaluations (Department of Health 2017b). This is a welcome innovation, particularly if these processes can be further developed for application to program design. Greater Aboriginal and Torres Strait Islander participation in co-design processes will strengthen imperatives to ensure that the program planning and evaluation cycle is transparent to communities.

Data sovereignty is critical to self-determination. Aboriginal and Torres Strait Islander people should have both leadership and ownership with respect to evaluation reports and data about their communities. Sharing data with communities is often done as part of evaluation. It can be formally integrated in the evaluation, as in the Sentinel Sites Evaluation, or can be part of the ethical obligations of the evaluator. Approaches where this is directly funded are likely to ensure that this important step in evaluation is completed in a way that meets the ethical requirements of evaluation. Ideally, communities would hold their own data; however, achieving this will involve identifying appropriate host organisations within communities and developing data management capacity within communities. An interim pathway may involve establishing a third-party data repository. This would have to be established in a way that would respect data sovereignty and enable communities to access their data.

The project has identified areas where the ability of evaluations to deliver benefit to Aboriginal and Torres Strait Islander communities could be strengthened. These include:

- increased transparency and accountability
- incorporating principles for working with Aboriginal and Torres Strait Islander people in programs
- use of ethical frameworks that recognise the responsibilities of all parties in evaluation
- Aboriginal and Torres Strait Islander leadership and ownership, which should be supported at all phases of the program planning and evaluation cycle.

Overall, there was a high level of recognition of limitations of current practice from a range of perspectives. The will to improve practice was reflected in positive initiatives to address these limitations. However, there was also recognition that systemic change is required to fully implement the changes required to improve the benefit of evaluation to Aboriginal and Torres Strait Islander communities.

6. Recommendations

Transparency and accountability around Aboriginal and Torres Strait Islander health evaluations should be improved by ensuring access to tender documents, evaluation reports and documentation of responses to evaluations.

The project has reviewed all evaluations of programs addressing health and wellbeing among Aboriginal and Torres Strait Islander people where a request for tender was publicly advertised in the past ten years. Direct requests were made to tenders sites, relevant websites and databases, which were searched and listed contacts individually followed up. Only 5 per cent of tender documents and 33 per cent of evaluation reports were able to be obtained. Positive initiatives are underway to ensure that evaluation results are released. However, this should be expanded to include past evaluations. Documenting responses to evaluations and making these available is also crucial to transparency and accountability and in communicating benefit to Aboriginal and Torres Strait Islander communities.

Evaluations of programs addressing Aboriginal and Torres Strait Islander health and wellbeing should use the framework to address government principles for working with Aboriginal and Torres Strait Islander people.

All Australian governments have developed principles for working with Aboriginal and Torres Strait Islander people. These should be incorporated into all programs and could therefore logically be expected to be reflected in evaluations. Part A of the evaluation framework outlines indicators that can be used to assess this but evaluators should use whatever is most appropriate to the local context. If particular principles are not invoked in a program, this should be noted.

Evaluations of programs addressing Aboriginal and Torres Strait Islander health and wellbeing should use ethical frameworks that recognise the responsibilities of all parties in evaluation and make optimal use of their capabilities to deliver health benefit.

Benatar and Singer (2000) have proposed 'a new, proactive research ethics concerned with reducing inequities in global health and achieving justice in health research and health care' (pp825). These new ethical frameworks for ensuring that research and evaluation deliver health justice identify specific obligations for commissioners, evaluators and program implementers (Ruger 2009). Parties are assigned obligations because the functions they typically assume make them particularly capable of fulfilling the obligations (Pratt & Hyder 2015; Pratt & Loff 2014). This approach expands upon but is not inconsistent with existing approaches to ethics in Aboriginal and Torres Strait Islander health (NHMRC 2003, 2010).

Aboriginal and Torres Strait Islander leadership and ownership should be supported at all phases of the program planning and evaluation cycle.

There is strong recognition that Aboriginal and Torres Strait Islander people need to be involved in program development and evaluation. However, this often consists of consultation rather than leadership roles. Where Aboriginal and Torres Strait Islander leadership is recognised, it is more likely to be at local levels of decision making, often when program parameters have already been defined. Meaningful engagement of Aboriginal and Torres Strait Islander people at any point in the program planning and evaluation cycle will add value. However, improving the benefit delivered through evaluation to Aboriginal and Torres Strait Islander people will require a systemic approach to engagement that enables both leadership and ownership.

Supporting the recommendations

Tender processes should support evaluation proposals that are most likely to benefit Aboriginal and Torres Strait Islander people.

The tender process provides commissioners with an opportunity to define their preferences in the conduct of an evaluation and the criteria against which evaluators are selected. This is a powerful agenda-setting activity in any evaluation. Defining selection criteria around the benefit provided to Aboriginal and Torres Strait Islander people would strengthen this imperative in evaluation.

Evaluation contracts and agreements should be consistent with principles for working with Aboriginal and Torres Strait Islander people and ethical frameworks.

Evaluation contracts, particularly around intellectual property, are often at odds with community expectations and ethical frameworks. They are also primarily between the commissioner and the evaluator. Evaluators and the community may have their own agreements, although these in turn need to be consistent with contractual arrangements. There is often no clear pathway for community access to evaluation data, although under ethical frameworks they would be expected to 'own' this data. Developing contracts and agreements that support community engagement and ownership of data would improve benefits to Aboriginal and Torres Strait Islander people and align contracting with ethical frameworks.

Tender documents, evaluation reports and responses to evaluation should be stored on a publicly accessible database.

Tender documents, evaluation reports and responses to evaluation should be stored on a publicly accessible database. If there are sensitive issues about the release of some information, it can be embargoed for a period of time. The Australian Indigenous HealthInfoNet is comprehensive, well regarded and authoritative in its reviews of policy, but its utility is limited to what is available on government websites. (Note: the Australian Indigenous HealthInfoNet also includes peer-reviewed literature but this is not subject to the same concerns.) Expanding the Australian Indigenous HealthInfoNet to include direct archiving may assist in enabling ongoing access to the evidence base.

Past evaluation reports should be released.

Past evaluation reports should be released so that the evidence base around policy and programs is more transparent.

A directory of current evaluations should be developed.

Developing a directory of current evaluations would help address issues around the level of evaluation in Aboriginal and Torres Strait Islander health and wellbeing. It would also provide a platform for commissioners, communities and evaluators to share learnings.

Evaluation data should be stored so that they are accessible to the communities in which data are collected, and local data management/analysis capability should be supported.

Ideally, Aboriginal and Torres Strait Islander communities should host repositories for their own data. However, considerable capacity building would be required to make this possible. In the interim, hosting data with a third-party organisation should be considered. Any such arrangement would have to respect data sovereignty, as well as security.

Training opportunities should be provided to support Aboriginal and Torres Strait Islander leadership in evaluation and participation in co-design.

Training to specifically support Aboriginal and Torres Strait Islander leadership in evaluation will improve benefits to the community both through employment and by improving evaluation itself. Aboriginal Community Controlled Health Organisations (ACCHOs) have a potential leadership role in promoting the better incorporation of principles for working with Aboriginal and Torres Strait Islander people. Primary Health Networks may be well placed to support training opportunities.

Longer-term partnerships should be developed to support Aboriginal and Torres Strait Islander leadership in evaluation and participation in co-design.

Optimally, supporting a greater focus on co-design and the associated investment in training may require the development of longer-term partnership arrangements with communities. These could potentially be supported at regional level with support from Primary Health Networks and ACCHOs.

Evaluation reports should report against principles for working with Aboriginal and Torres Strait Islander people both in terms of the program and evaluation itself.

Clear reporting against principles for working with Aboriginal and Torres Strait Islander people would help develop the evidence base around the application of these principles.

Evaluation reports should report against ethical frameworks both in terms of the program and evaluation itself.

Clear reporting against ethical frameworks would help develop the evidence base around the application of these frameworks.

New models of developing programs and evaluations should be considered.

The project primarily considered evaluations where the evaluator was commissioned to complete an evaluation after a program was developed. A number of emergent approaches to program development and evaluation are more closely embedded within communities.

7. References

- AH&MRC Ethics Committee 2016, *AH&MRC Guidelines for Research into Aboriginal Health: Key Principles*, AH&MRC, Surry Hills, NSW. Viewed on 24 December 2017 at <www.ahmrc.org.au/media/resources/ethics/ethics-application-resources/271-ah-mrc-guidelines-for-research-into-aboriginal-health-key-principles-1/file.html>.
- AHMAC (Australian Health Ministers' Advisory Council) Standing Committee on Aboriginal and Torres Strait Islander Health Working Party 2004, *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health, 2004–2009*, AHMAC, Canberra.
- AHWP (Australian Institute of Health and Welfare) 2017, *Aboriginal and Torres Strait Islander Health Performance Framework*. Viewed on 22 February 2018 at <www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents/summary>.
- Arkles, R. 2006, *Overseas Trained Doctors in Aboriginal and Torres Strait Islander Health Services: A Literature Review*, Muru Marri Indigenous Health Unit Monograph Series, MMIHU & Cooperative Research Centre for Aboriginal Health, Darwin.
- AHWP (Australian Institute of Health and Welfare) & Australian Institute of Family Studies 2017, *Closing the Gap Clearinghouse*. Viewed on 5 September 2017 at <<http://www.aihw.gov.au/closingthegap/>>.
- Bailie, R., Griffin, J., Kelaher, M., McNeair, T., Percival, N., Laycock, A. & Schierhout, G. 2013, *Sentinel Sites Evaluation: Final Report*, Australian Government Department of Health and Ageing, Canberra.
- Bailie, R., Stevens, M., McDonald, E., Brewster, D. & Guthridge, S. 2010, 'Exploring Cross-sectional Associations between Common Childhood Illness, Housing and Social Conditions in Remote Australian Aboriginal Communities', *BMC Public Health*, vol. 10, p. 10.
- Bainbridge, R., Tsey, K., McCalman, J., Kinchin, I., Saunders, V., Watkin Lui, F., Cadet-James, Y., Miller, A. & Lawson, K. 2015, 'No One's Discussing the Elephant in the Room: Contemplating questions of research impact and benefit in Aboriginal and Torres Strait Islander Australian health research', *BMC Public Health*, vol. 15, p. 10.
- Benatar, S. R. & Singer, P. A. 2000, 'A New Look at International Research Ethics', *British Medical Journal*, vol. 321, no. 7264, pp. 824–6.
- Brown, A., O'Shea, R. L., Mott, K., McBride, K. F., Lawson, T., Jennings, G. L. & Essential Service Standards for Equitable National Cardiovascular Care for Aboriginal and Torres Strait Islander people (ESSENCE) Steering Committee 2015, 'A Strategy for Translating Evidence into Policy and Practice to Close the Gap—Developing essential service standards for Aboriginal and Torres Strait Islander cardiovascular care', *Heart Lung and Circulation*, vol. 24, no. 2, pp. 119–25.
- Brown, C. H., Curran, G., Palinkas, L. A., Aarons, G. A., Wells, K. B., Jones, L., Collins, L. M., Duan, N., Mittman, B. S., Wallace, A., Tabak, R. G., Ducharme, L., Chambers, D. A., Neta, G., Wiley, T., Landsverk, J., Cheung, K. & Cruden, G. 2017, 'An Overview of Research and Evaluation Designs for Dissemination and Implementation', *Annual Review of Public Health*, vol. 38, no. 1, pp. 1–22.
- Brunger, F. & Wall, D. 2016, "What Do They Really Mean by Partnerships?" Questioning the unquestionable good in ethics guidelines promoting community engagement in Indigenous health research', *Qualitative Health Research*, vol. 26, no. 13, pp. 1862–77.
- CDC (Centers for Disease Control and Prevention, US Department of Health and Human Services Office of the Director, Office of Strategy and Innovation) 2011, *Introduction to Program Evaluation for Public Health Programs: A Self-study Guide*, Centers for Disease Control and Prevention, Atlanta, GA.
- Centre for Epidemiology and Evidence 2017, *Developing and Using Program Logic: A Guide*, Evidence and Evaluation Guidance Series, NSW Health Population and Public Health Division, Sydney.
- Chen, H. T. & Rossi, P. H. 1989, 'Issues in the Theory-driven Perspective', *Evaluation and Program Planning*, vol. 12, no. 4, pp. 299–306.
- Chen, H. T. 2012, 'Theory-driven Evaluation: Conceptual framework, application and advancement', in R. Strobl, O. Lobermeier & W. Heitmeyer (eds), *Evaluation von Programmen und Projekten für eine demokratische Kultur*, Springer Fachmedien Wiesbaden, Wiesbaden, pp. 17–40.
- Chen, H. T. n.d., Theory-driven Evaluation: Conceptual Framework, Methodology and Application, presentation, Center for Disease Control and Prevention. Viewed on 19 February 2018 at <www.ceval.de/modx/uploads/pdf/Chen_presentation.pdf>.
- Chief Health Officer Australian Capital Territory 2014, *Draft ACT Aboriginal and Torres Strait Islander Health Plan: Priorities for the Next Five Years 2016–2020*, Australian Capital Territory Government, Canberra.
- Christie, C. A. & Alkin, M. C. 2008, 'Evaluation Theory Tree Re-examined', *Studies in Educational Evaluation*, vol. 34, no. 3, pp. 131–5.
- CIRCA (Cultural and Indigenous Research Centre Australia) & Anne Markiewicz and Associates 2013, *Evaluation of Indigenous Justice Programs Project B: Offender Support and Reintegration: Final Report*, Attorney-General's Department, Canberra.

- COAG (Council of Australian Governments) 2008, *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*, COAG, Canberra.
- Community Affairs References Senate Committee 2011, 'Previous Reviews' (Chapter 4), *The Effectiveness of Special Arrangements for the Supply of Pharmaceutical Benefits Scheme (PBS) Medicines to Remote Area Aboriginal Health Services*, Commonwealth of Australia, Canberra.
- Cross, T. L., Bazron, B., Dennis, K. W. & Isaacs, M. R. 1989, *Towards a Culturally Competent System of Care*, Child and Adolescent Service System Program Technical Assistance Center, Washington, DC.
- Dawson, A. P., Cargo, M., Stewart, H., Chong A. & Daniel, M. 2013, 'Identifying Multi-level Culturally Appropriate Smoking Cessation Strategies for Aboriginal Health Staff: A concept mapping approach', *Health Education Research*, vol. 28, no. 1, pp. 31–45.
- Department of Finance 2017, *The Enhanced Commonwealth Performance Framework*. Viewed on 22 February 2018 at <www.finance.gov.au/resource-management/performance/>.
- Department of Health 2010, *Aboriginal Health Care Plan 2010–2016*, State of South Australia, Adelaide.
- Department of Health 2012, *Koolin Balit Victorian Government Strategic Directions for Aboriginal Health 2012–2022*, State of Victoria, Melbourne.
- Department of Health 2013, *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*, Australian Government, Canberra.
- Department of Health 2014, *Northern Territory Aboriginal Health Plan 2015–2018*, Northern Territory Department of Health, Darwin.
- Department of Health 2015, *WA Aboriginal Health and Wellbeing Framework 2015–2030*, State of Western Australia, Perth.
- Department of Health 2017a, 'Evaluation of the Regional Immunisation Initiatives Program' (tender), State Government of Victoria. Viewed on 24 December 2017 at <<https://tenders.vic.gov.au/tenders/tender/display/tender-details.do?id=5477&action=display-tender-details>>.
- Department of Health 2017b, 'Services to Evaluate the Effectiveness of Primary Health Care for Aboriginal and Torres Strait Islander People', ATM ID Health/16–17/02761. Viewed on 22 February 2018 at <www.tenders.gov.au/?event=public.atm.showClosed&ATMUUID=8D595DD7-08D9-C5D2-8D2B8F68EE725A74>.
- Department of Health and Ageing 2007, *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013: Australian Government Implementation Plan 2007–2013*, Commonwealth of Australia, Canberra.
- Department of Justice and Regulation 2017, *Aboriginal Social and Emotional Wellbeing Plan*, State Government of Victoria, Melbourne. Viewed on 19 February 2018 at <www.justice.vic.gov.au/home/your+rights/aboriginal+justice+agreement/aboriginal+social+and+emotional+wellbeing+plan>.
- DiGiacomo, M., Davidson, P. M., Davison, J., Moore, L. & Abbott, P. 2007, 'Stressful Life Events, Resources and Access: Key considerations in quitting smoking at an Aboriginal Medical Service', *Australian and New Zealand Journal of Public Health*, vol. 31, no. 2, pp. 174–6.
- Dimer, L., Dowling, T., Jones, J., Cheetham, C., Thomas, T., Smith, J., McManus, A. & Maiorana, A. J. 2013, 'Build It and They Will Come: Outcomes from a successful cardiac rehabilitation program at an Aboriginal Medical Service', *Australian Health Review*, vol. 37, no. 1, pp. 79–82.
- Dixon, T., Mir, A., Cox, E. & Wilson, J. 2009, *Aboriginal Knowledge and Intellectual Property Protocol: Community Guide*, 2nd edition, Ninti One Limited, Alice Springs, NT. Viewed on 1 March 2018 at <www.nintione.com.au/resource/Aboriginal-Knowledge-and-IP-Protocol-Community-Guide-booklet-A5.pdf>.
- Durey, A., Wynaden, D., Thompson, S. C., Davidson, P. M., Bessarab B. D. & Katzenellenbogen, J. M. 2012, 'Owning Solutions: A collaborative model to improve quality in hospital care for Aboriginal Australians', *Nursing Inquiry*, vol. 19, no. 2, pp. 144–52.
- Dwyer, J., O'Donnell, K., Lavoie, J., Marlina, U. & Sullivan, P. 2009, *The Overburden Report: Contracting for Indigenous Health Services*, Flinders University and Cooperative Research Centre for Aboriginal Health, Darwin.
- Empowered Communities 2015, *Empowered Communities: Empowered Peoples Design Report*, Wunan Foundation Inc., Kununurra, WA.

- FaCSIA (Department of Families, Community Services and Indigenous Affairs) 2010, *Directory of Commonwealth Government Evaluations, Audits and Review of Indigenous-specific and Relevant Mainstream Plans 2002–2014*, Office of Indigenous Policy Co-ordination, Canberra. Viewed on 21 December 2017 at <www.yumpu.com/en/document/view/28164603/directory-of-commonwealth-government-evaluations-audits-and->.
- Ferdinand, A. S., Paradies, Y. & Kelaher, M. 2017, 'Enhancing the Use of Research in Health-promoting, Anti-racism Policy', *Health Research Policy and Systems*, vol. 15, p. 10.
- Greene, J. C., DeStefano, L., Burgon, H. & Hall, J. 2006, 'An Educative, Values-engaged Approach to Evaluating STEM Educational Programs', *New Directions for Evaluation*, no. 109, pp. 53–71.
- Halliday, D. & Segal, L. 2012, *What Works in Indigenous Primary Health Care Health Reform? A Review of the Evidence*, University of South Australia.
- Haswell, M. R., Blignault, I., Fitzpatrick, S. & Jackson Pulver, L. 2013, *The Social and Emotional Wellbeing of Indigenous Youth: Reviewing and Extending the Evidence and Examining its Implications for Policy and Practice*, Muru Marri, School of Public Health and Community Medicine, UNSW Medicine, Sydney.
- Haswell, M. R., Kavanagh, D., Tsey, K., Reilly, L., Cadet-James, Y., Laliberte, A., Wilson, A. & Doran, C. 2010, 'Psychometric Validation of the Growth and Empowerment Measure (GEM) Applied with Indigenous Australians', *Australian and New Zealand Journal of Psychiatry*, vol. 44, no. 9, pp. 791–9.
- Haswell, M., Williams, M., Blignault, I., Grand Ortega, M. & Jackson Pulver, L. 2014, *Returning Home, Back to Community from Custodial Care: Learnings from the First Year Pilot Project Evaluation of Three Sites around Australia*, Muru Marri, School of Public Health and Community Medicine, UNSW.
- Healing Foundation 2015, *Our Men Our Healing: Evaluation Report*, Healing Foundation, Barton, ACT.
- Health Behaviour Research Group 2016, *Chronic Care Service Enhancements Program Evaluation*. Viewed on 24 December 2017 at <www.health.nsw.gov.au/research/Documents/CCSEP-full-report.pdf>.
- Howse, G. 2011, *Legally Invisible—How Australian Laws Impede Stewardship and Governance for Aboriginal and Torres Strait Islander Health*, Lowitja Institute, Melbourne.
- Hudson, S. 2017, *Evaluating Indigenous Programs: A Toolkit for Change*, Centre for Independent Studies, Sydney.
- Johnston, E. 1991, *Final Report of the Royal Commission into Aboriginal Deaths in Custody*, Royal Commission into Aboriginal Deaths in Custody, Canberra.
- Kelaher, M., Sabanovic, H., La Brooy, C., Lock, M., Lusher, D. & Brown, L. 2014, 'Does More Equitable Governance Lead to More Equitable Health Care? A case study based on the implementation of health reform in Aboriginal health Australia', *Social Science & Medicine*, vol. 123, pp. 278–86.
- King, J., McKegg, K., Oakden, J. & Wehipeihana, N. 2013, 'Rubrics: A method for surfacing values and improving the credibility of evaluation', *Journal of Multidisciplinary Evaluation*, vol. 9, no. 21, pp. 11–20.
- Laycock, A., Bailie, J., Matthews, V. & Bailie, R. 2016, 'Interactive Dissemination: Engaging stakeholders in the use of aggregated quality improvement data for system-wide change in Australian Indigenous primary health care', *Frontiers in Public Health*, vol. 4, p. 8.
- Lokuge, K., Thurber, K., Calabria, B., Davis, M., McMahon, K., Sartor, L., Lovett, R., Guthrie, J. & Banks, E. 2017, 'Indigenous Health Program Evaluation Design and Methods in Australia: A systematic review of the evidence', *Australian and New Zealand Journal of Public Health*, vol. 41, no. 5, pp. 480–2.
- Lomas, J. 1997, 'Research and Evidence-based Decision Making', *Australian and New Zealand Journal of Public Health*, vol. 21, no. 5, pp. 439–41.
- McCalman, J., Tsey, K., Clifford, A., Earles, W., Shakeshaft, A. & Bainbridge, R. 2012, 'Applying What Works: A systematic search of the transfer and implementation of promising Indigenous Australian health services and programs', *BMC Public Health*, vol. 12, p. 7.
- Mitchell, P., Pirkis, J., Hall, J. & Haas, M. 2009, 'Partnerships for Knowledge Exchange in Health Services Research, Policy and Practice', *Journal of Health Services Research & Policy*, vol. 14, no. 2, pp. 104–11.
- Muir, S. & Dean, A. 2017, *Evaluating the Outcomes of Programs for Indigenous Families and Communities*, Australian Institute of Family Studies, Canberra.

- NACCHO (National Aboriginal Community Controlled Health Organisation) n.d., 'Definitions'. Viewed on 22 December 2017 at <www.naccho.org.au/about/aboriginal-health/definitions/>.
- Nathan, S., Bunde-Birouste, A. & Croft, T. 2016, *Evaluation of REACCH: Capacity Building in Aboriginal Research*, School of Public Health and Community Medicine, UNSW, Sydney.
- National Congress of Australia's First Peoples 2016, *Aboriginal and Torres Strait Islander Peak Organisations Unite: The Redfern Statement*, National Congress of Australia's First Peoples, Sydney.
- NHMRC (National Health and Medical Research Council) 2003, *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*, NHMRC, Canberra.
- NHMRC 2010, *The NHMRC Road Map II: A Strategic Framework for Improving the Health of Aboriginal and Torres Strait Islander People through Research*, NHMRC, Canberra.
- NSW Ministry of Health 2012, *NSW Aboriginal Health Plan 2013–2023*, State of NSW, Sydney.
- Panaretto, K., Wenitong, M., Button, S. & Ring, I. T. 2014, 'Aboriginal Community Controlled Health Services: Leading the way in primary care', *Medical Journal of Australia*, vol. 200, no. 11, pp. 649–52.
- Pholi, K., Black, D. & Richards, C. 2009, 'Is "Close the Gap" a Useful Approach to Improving the Health and Wellbeing of Indigenous Australians?', *Australian Review of Public Affairs*, vol. 9, no. 2, pp. 1–14.
- PM&C (Department of the Prime Minister and Cabinet) 2017, *Indigenous Advancement Strategy Evaluation Framework: Exposure Draft*, PM&C, Canberra.
- Pratt, B. & Loff, B. 2014, 'A Framework to Link International Clinical Research to the Promotion of Justice in Global Health', *Bioethics*, vol. 28, no. 8, pp. 387–96.
- Pratt, B. H. & Hyder, A. A. 2015, 'Global Justice and Health Systems Research in Low and Middle-income Countries', *Journal of Law, Medicine, & Ethics*, vol. 43, no. 1, pp. 143–61.
- Productivity Commission 2013, *Better Indigenous Policies: The Role of Evaluation—Roundtable Proceedings*, Productivity Commission, Canberra.
- Queensland Health 2010, *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033*, State of Queensland, Brisbane.
- Rootman, I., Goodstadt, M., Hyndman, B., McQueen, D. V., Potvin, L., Springett, J. & E. Ziglio (eds) 2001, *Evaluation in Health Promotion: Principles and Perspectives*, WHO Regional Publications, European Series, No. 92., WHO Europe, Copenhagen.
- Rowley, K., Doyle, J., Johnston, L., Reilly, R., McCarthy, L., Marika, M., Riley, T., Atkinson, P., Firebrace, B., Calleja, J. & Cargo, M. 2015, 'Strengths and Limitations of a Tool for Monitoring and Evaluating First Peoples' Health Promotion from an Ecological Perspective', *BMC Public Health*, vol. 15, no. 1, p. 1215.
- Ruger, J. P. 2009, 'Global Health Justice', *Public Health Ethics*, vol. 2, no. 3, pp. 261–75.
- Russell, L. 2015, 'Closing the Gap: Productivity Commission shows how far there is to go', *Sydney Morning Herald*, 6 December. Viewed on 22 February 2018 at <www.smh.com.au/comment/closing-the-gap-productivity-commission-shows-how-far-there-is-to-go-20151204-glfvo8.html>.
- SCRGSP (Steering Committee for the Review of Government Service Provision) 2014, *Overcoming Indigenous Disadvantage: Key Indicators 2014*, Productivity Commission, Canberra.
- SCRGSP (Steering Committee for the Review of Government Service Provision) 2016, *Overcoming Indigenous Disadvantage: Key Indicators 2016*, Productivity Commission, Canberra.
- Shelton, J. D. 2014, 'Evidence-based Public Health: Not only whether it works, but how it can be made to work practicably at scale', *Global Health: Science and Practice*, vol. 2, no. 3, p. 253.
- Smullen, F. 2008, *Putting Cross Cultural Policy into Practice*, The University of Melbourne.
- Stephenson, J. 2012, *Evaluation of the Bila Muuji Smoking Cessation Project*. Viewed on 24 December 2017 at <[www.health.gov.au/internet/main/publishing.nsf/content/ba3f204ab5b83f9dca257bf0001a8e12/\\$file/foi_067-1213_document_7_-_final_evaluation_of_the_bila_muuji_smoking_cessation_project_aug_12.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/ba3f204ab5b83f9dca257bf0001a8e12/$file/foi_067-1213_document_7_-_final_evaluation_of_the_bila_muuji_smoking_cessation_project_aug_12.pdf)>.

- Stufflebeam, D. L. 2003, 'The CIPP Model for Evaluation', in *The International Handbook of Educational Evaluation*, Kluwer Academic, Dordrecht and London, pp. 31–62.
- Thompson, S. J., Gifford, S. M. & Thorpe, L. 2000, 'The Social and Cultural Context of Risk and Prevention: Food and physical activity in an urban Aboriginal community', *Health Education & Behavior*, vol. 27, no. 6, pp. 725–43.
- Trochim, W. M., Cabrera, D.A., Milstein, B., Gallagher, R. S. & Leischow, S. J. 2006, 'Practical Challenges of Systems Thinking and Modeling in Public Health', *American Journal of Public Health*, vol. 96, no. 3, pp. 538–46.
- Tsey, K., McCalman, J., Bainbridge, R. & Brown, C. 2012, *Improving Indigenous Community Governance through Strengthening Indigenous and Government Organisational Capacity*, Resource sheet no. 10, produced for the Closing the Gap Clearinghouse, Australian Institute of Health and Welfare, Canberra, & Australian Institute of Family Studies, Melbourne.
- United Nations 2008, *United Nations Declaration on the Rights of Indigenous Peoples*. Viewed on 21 December 2017 at <www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf>.
- Urbis 2009, *Evaluation of the Healthy for Life Program*, Department of Health and Ageing, Woden, ACT.
- VACCHO (Victorian Aboriginal Community Controlled Health Service) 2012. *An Evaluation of a Series of Harm Reduction and Alcohol and Drug Awareness Activities within Victorian Aboriginal Communities*. <http://www.vaccho.org.au/assets/01-RESOURCES/TOPIC-AREA/RESEARCH/VACCHO-NOT-EVERYONE-HAS-THAT-SUPPORT.pdf>
- Victoria, C. G., Habicht, J.-P. & Bryce, J. 2004, 'Evidence-based Public Health: Moving beyond randomized trials', *American Journal of Public Health*, vol. 94, no. 3, pp. 400–05.
- Vujcich, D., Rayner, M., Allender, S. & Fitzpatrick, R. 2016, 'When There Is Not Enough Evidence and When Evidence Is Not Enough: An Australian Indigenous smoking policy study', *Frontiers in Public Health*, doi: 10.3389/fpubh.2016.00228.
- Walter, M. & Andersen, C. 2013, *Indigenous Statistics: A Quantitative Methodology*, Left Coast Press, Walnut Creek, CA.
- Wild, R. & Anderson, P. 2007, *Ampe Akelyernemane Meke Mekarle 'Little Children are Sacred': Report of the Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*, Northern Territory Government, Darwin.
- Williams, E., Guenther, J. & Arnott, A. 2011, *Beyond Informed Consent: How Is it Possible to Ethically Evaluate Indigenous Programs?*, NARU Public Seminar Series, vol. 23, NARU, Darwin.
- Wilson, G., Willis, J., Totterdell, J., Gupta, A., Chong, A., Clarke, A., Winters, M., Donohue, K. & Posenelli, S. 2017, *Aboriginal Identification in Hospitals Quality Improvement Program*, NSW Department of Health, Sydney.
- Yarmintali Consultancy 2010, *Lungurra Ngoora Community Care Service Evaluation Report*. Viewed on 19 February 2018 at <<http://kams.org.au/wp-content/uploads/2015/04/Lungurra-Ngoora-Community-Care-Service-Evaluation-Report-Aug10-Final.pdf>>.
- Young, C., Tong, A., Sherriff, S., Kalucy, D., Fernando, P., Muthayya, S. & Craig, J. C. 2016, 'Building Better Research Partnerships by Understanding How Aboriginal Health Communities Perceive and Use Data: A semistructured interview study', *BMJ Open*, vol. 6, no. 4.

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