Aboriginal engagement, Aboriginal evaluation: Owning an evaluation through comprehensive co-design

Lisa Jackson Pulver [a,b] and Tosh Kelly [c]

[a] *Health Performance Council, South Australia, Australia*
[b] *Deputy Vice Chancellor Indigenous Strategy and Services, The University of Sydney, Sydney, New South Wales, Australia [portions of this work were undertaken while the author was at Western Sydney University]*
[c] *Aboriginal Experts by Experience, Country Health SA Local Health Network, South Australia, Australia*

Corresponding contact: South Australian Health Performance Council secretariat, e-mail HealthHealthPerformanceCouncil@sa.gov.au

Presented at the International Evaluation Conference, Sydney, Australia, 18 Sep 2019

Abstract

The various state-run health services in South Australia are charged with implementing 'an effective consumer engagement system'. In 2015, one of the state's several local health networks published a strategy for engagement with its Aboriginal consumers and community members. As part of the South Australian Health Performance Council's remit to review the effectiveness of the state's community engagement methods, the Council decided to evaluate how well that engagement strategy had been implemented.

As the strategy being evaluated was about Aboriginal health consumers and community members, it was necessary that they themselves would best have the experience and legitimacy necessary to guide our review. The Council therefore set up a governing advisory group made up of people with a strong mix of Aboriginal health perspectives, including – crucially – members of the very same grass roots Aboriginal community register that was itself the flagship creation of the strategy being evaluated.

This paper introduces the project governance and the co-creation of an Aboriginal advisory group and explains the lengthy but critical collaborative process the advisory group then used to develop an agreed evaluation logic model to inform the design of the evaluation. The paper then explains how the advisory group provided governance for the substantive components of the evaluation, including advice on protecting Aboriginal cultural property by procuring external expert assistance from an Aboriginal-led social research firm to undertake primary data collection. Finally, the paper presents the iterative validation process used to prove and refine the draft findings and results to ensure that they resonated with the community.

Introduction

Public hospitals in Australia are run by legal entities called local hospital networks[1]; in each state, these are known by a different name, but throughout Australia, there exist a number of these networks responsible for providing public hospital services and community health services either in a specified geographical area or as a state-wide specialist function. Prior to July 2019, one such network provided services for country South Australia: Country Health SA Local Health Network Inc.

South Australia's population is small (approx. 1.7 million)[2] and the state has a city-centric population distribution inasmuch as only a quarter of the population as a whole live outside the Adelaide area; however, for Aboriginal residents, the proportion living in the 99.7% of the area of the state outside Adelaide is closer to one half[3]. Hence, Country Health SA Local Health Network ('Country Health SA'), was responsible for the hospital provision in what is a geographically vast area with a low population of whom, relative to the whole state, a proportionately higher number are Aboriginal people.

It is South Australian government policy that the state's local hospital networks provide for the implementation of effective consumer engagement systems[4]. In 2015, in partial fulfilment of this obligation, Country Health SA released their *Aboriginal Community and Consumer Engagement Strategy* ('the Strategy')[5], which they had developed in consultation with Aboriginal health system consumers in their region.

In late 2016, South Australia's Health Performance Council ('the Council')[i], a statutory body with functions that include the provision of advice to the state's health minister on the effectiveness of health system community and individual engagement[6], embarked on a substantial project to inquire into and report on how well that strategy had been implement-

[i] The first author, Professor Lisa Jackson Pulver AM, is a member of the Health Performance Council and was the Council's sponsor for this work.

ed by Country Health SA in the short term. The findings of the review, which are beyond the scope of this paper, were published in January 2019[7].

Methods

Project governance

The Strategy being about health consumers and community members, the Council recognised early that Aboriginal consumers and community members alone would be those with the experience and legitimacy to guide the project. The Council therefore convened an advisory group ('Group'), chaired by the first author (LJP), soliciting and obtaining representation on the group from a variety of Aboriginal perspectives, including: the Aboriginal Health Council of South Australia, the Council of Aboriginal Elders, representatives from Country Health SA, a representative from the state government's health department, and consumer and community representatives. The *Experts by Experience* register had been constituted under the Strategy by Country Health SA as a distrubuted group of consumers and community members who volunteered to take some grass roots involvement in the design and delivery of health services and to act in some manner as a conduit with their wider community. It was considered to be critical that members of that group be engaged in the project to review the Strategy by way of service on the Group.

The Group did not strictly have decision-making powers, which was reserved to the statutory body that was commissioning the work, South Australia's Health Performance Council; but the group was given the authority to advise on project documents and to give strategic advice around the project's overall scope and direction. To secure that the group had a remit that extended truly to co-design authority of the evaluation rather than just an advisory role, the Council delegated to the group itself the ability to take ownership of its own terms of reference, its first activity being to agree these.

Having ownership of its own terms of reference, the Group turned next to ownership of its constitution and found itself to be deficient in some core Aboriginal community and consumer representation. It was not until four months after being formed that the group's makeup therefore achieved some stability and self-identified completeness, with new members at that point having joined to provide both male and female Aboriginal Elder representation and an Aboriginal representative drawn from the Country Health SA *Aboriginal Experts by Experience* register[ii].

A majority of the members of the Group were not employed by the state government or otherwise paid to be participating in the work of the group. In recognition of the value of their being on the group, the Council provided a modest sitting fee to those who were not otherwise paid, and covered travel and other expenses to ensure that no member of the group was left out of pocket on account of their participation. On their own determination, the group's value was also honoured by a commitment – that was met – that at least one of their meetings would be held outside of the metropolitan region of Adelaide (South Australia's small but relatively populous capital city).

Evaluation design

On initial summary assessment of the Strategy, the Group found that the Strategy did not specify what would be its intended outcomes or set out any coherent discussion upon a theory of change, which meant that there was no inherent set of outcomes to evaluate. The group therefore set about inferring a logic model for the Strategy with defined outputs and outcomes for assessment. Upon the group's own guidance, an expert Aboriginal facilitator was engaged to lead the group in workshop to draft the model, which was then much refined and revised by the group over six months of deliberations.

In parallel with the finalisation of the evaluation logic model, the group spent almost a year of elapsed time methodically examining the Strategy and applying their diverse knowledge and experiences to determine the questions that they wanted the project to explore and the most scientifically and culturally appropriate methods to answer them. The Council's initiation of the evaluation project had provided a broad scope of what was to be achieved, but considerable latitude remained as to more expressly what was to be evaluated and how. It is beyond the scope of this paper to examine in detail the chosen methods, but it may be noted that these amounted to a mixed-methods review consisting of: a desktop review of available data and information; a primary collection of quantitative and qualitative survey date; and a primary collection of qualitative data from a series of focus groups.

Delivery governance

The work of the Group was central to discharging the Council's obligations to Aboriginal cultural property and its commitment to compliance with the South

[ii] The second author, Tosh Kelly, served on the advisory group in this capacity from March 2018.

Australian Aboriginal Health Research Accord[8]. Upon the group's advice, and although considered by the Council that the work would not amount to human research as the term is understood by research ethics committee, there was nonetheless a consensus view to secure that the work would be conducted to the highest ethical standards. The group advised on the preparation of an application to the South Australian Aboriginal Health Research Ethics Committee; although that committee agreed with the initial analysis in advising that they did not require to provide oversight, the Council considers it important that efforts were made to discharge responsibilities to ethical conduct by making an application to the committee and taking on board the spirit and intent of the Aboriginal health research best practices[iii].

To better secure the protection of Aboriginal cultural property, the Group advised us to procure external expert assistance from an Aboriginal-led social research firm to undertake the primary data collection activities and deliver us a report of their work. The group recommended suitable firms and advised us on the selection of the successful bidder[iv]. The Group provided oversight and guidance throughout the delivery of the contractor's deliverables.

With cost and time constraints on the number of focus groups that the prime contractor could hold, the Group provided vital advice as to the correct locations of these and which remote locations could be validly held jointly with face-to-face location focus groups through video-conferencing. To honour properly the regional based constituents whose views were being solicited, the Group required that every one of these focus group sessions be held in regional South Australia rather than being operated remotely from Adelaide.

The primary data collection contractor provided a summary report of their findings along with some raw data as a core component of what would be needed for the final report of the evaluation. Along with other fresh material and original analysis by the Council's secretariat, much of the contractor's material was incorporated into a first draft of a final report. The Group provided drafting advice and had review authority over the final technical manuscript, thereby ensuring that the report was validly completed under their governance. An iterative approach was taken, the Group debating and advising on changes over multiple draft-review-redraft cycles.

The group also recommended the creation of a stand-alone community report for publication and that it be brief and aimed at the community. This was prepared by an expert Aboriginal writer appointed on the group's advice and written in accordance to their specifications.

Discussion

An evaluation of a public health strategy relating to Aboriginal community members had validity and the ability to resonate with those communities only by dint of being conducted from its inception under a proper model of co-design wherein the Aboriginal community members who were the subject of the Strategy took ownership of the evaluation project. It is not clear whether or how the project could have been delivered without the use throughout of a broad spectrum Group with diverse backgrounds and experiences to draw everything together and develop the outcomes and the questions to be examined in a way that was going to resonate with the Aboriginal community.

One of the key benefits observed of the consumer-led Group process was the ability for the most important decisions of the evaluation to be made with due deliberation by those with the necessary backgrounds and knowledge. In particular, this was the case for achieving representation in the group's membership to its own satisfaction, and the work to design the substantive components of the evaluation. Both took very much longer than had initially been expected and accounted for a large part of the resulting rescheduling of overall project completion. We consider the iterative and measured processes to be keenly demonstrative of the value of proper co-design: that it was only upon the deliberative advice of those Aboriginal health service consumers and community members on the Group that we were properly able to achieve an evaluation design that would meet the needs of the project and for which the results could be accepted. Given that the project's final report would be nugatory should it not be able to be used by South Australia's public hospitals to drive change in their engagement with Aboriginal patients and community members, the validity thus bestowed on the project and its report are critical.

Success in the process arose from a willingness by the Council to delegate authority to the Group to co-design the project and to invest properly in its completion. For instance, there were substantial costs incurred in taking the advice of the group to hold focus groups at a number of rural and remote locations across country South Australia, both directly for the

[iii] An application for ethical oversight was also made to, and granted by, the then South Australian Department for Health and Ageing's Human Research Ethics Committee.

[iv] Pricewaterhousecoopers Indigenous Consulting Pty Ltd

commissioning Council and indirectly in the value of the data collection contractor's engagement. The risks of not following this advice would have included the actual or apparent disregard of cultural considerations that we were advised would have made it difficult or impossible to collect good data or even any data at all.

Owing to the governance model, wherein determination of evaluation questions to be addressed and methods by which to address them, was devolved to a community-led Aboriginal Group, considerable good will was extended to the project by stakeholders allowing for the collection of more full and usable data for analysis; furthermore, both the evaluation project and its resultant evaluation report was accepted by the community as having validity and so can be more likely accepted as a driver for future change.

For the Health Performance Council, there were more deep-seated benefits too of the approach taken. The Council has long found itself striking out somewhat alone in its fulfilment of its functions, being South Australia's only external review body providing expert advice to the health minister on the performance of the state's health systems. The process of having a community led Group to guide the evaluation work has provided valuable lessons in the modelling of shared decision making for the more effective conduct of its future audit reviews.

Acknowledgements

We acknowledge all members of the project Group, for generously giving of their time, expertise and experiences. We pay respects to their Elders, past, present and future, and thank them for all they have done and continue to do

Funding for this project was provided by the South Australian Health Performance Council secretariat (a business unit of the South Australian Government's Department for Health and Wellbeing).

The Health Performance Council secretariat assisted with the substantive preparation of this paper.

Conflicts

The authors do not declare any conflicts of interest in respect of this paper.

References

[1] Council of Australian Governments. *National Health Reform Agreement*. 2011

[2] Based on Australian Bureau of Statistics data. *Australian Demographic Statistics, Dec 2018*, cat. no. 3101.0. June 2019.

[3] Based on data from Australian Bureau of Statistics. Extract from database *B07 Indigenous Status by Age by Sex*, ABS.stat, generated 08 August 2018

[4] Department for Health and Ageing, Government of South Australia. *A Framework for Active Partnership with Consumers and the Community*. Policy directive number D0306. December 2012.

[5] Country Health SA Local Health Network. *Aboriginal Community & Consumer Engagement Strategy*. May 2015.

[6] S. 11(1)(a)(iii), Health Care Act 2008 [South Australia].

[7] Health Performance Council, Government of South Australia. *Post-implementation review of Country Health SA's Aboriginal Community & Consumer Engagement Strategy*. January 2019.

[8] Wardliparingga Aboriginal Research Unit, South Australian Health and Medical Research Institute [lead organisation]. *South Australian Aboriginal Health Research Accord*. 2014