Urban Aboriginal Women and Health Services: Evaluating Health Care Together

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Introduction and background

I would like to acknowledge the co-authors and co-researchers who have significantly contributed to this paper. The ideas that I share here come from a collaborative project that has involved us all sharing our knowledge and ways of knowing. This presentation focuses on processes rather than results. It discusses how we sought effective ways of working that could improve Aboriginal women's health and well-being. The location of this study is a suburban Adelaide community health service.

I will begin by discussing how this research began. In Aboriginal health and evaluation it is very important to consider what research is being done and why, and whether it actually meets local community needs. This research/evaluation is a continuation of previous participatory research that began through the invitation of Aboriginal Elders and community women. I have worked as a community health nurse for many years in with Aboriginal women and they have been asking 'what about the young women?' And 'how can we get services to work out better for us.' As health and education staff we have been confused about how best to meet Aboriginal women's needs, amidst the ever-changing health and education systems that we work within.

The previous research was a collaborative project looking at what sexual health nurses needed to know and do in order to work well with young Aboriginal women in urban areas (Kelly 2004). Four themes arose from this and these were; the importance of trust relationships between health professionals and Elder women, community members and young Aboriginal women, that Aboriginal culture does exist and is considered important in urban areas, that women's health requires gender considerations, and that there needs to be a greater commitment to cultural models of practice to offset racist practices.

Overview of the study

The current research/evaluation project again works with three main groups of people, Aboriginal women, health and education services, and a reference group made up of Aboriginal Elder women and Aboriginal professionals. I am positioned in the middle of these groups, being a white researcher/practitioner who is working with all three groups. In some ways my role is that of listening and working with each of these groups as we come closer together in our ways of understanding ourselves and each other.

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We have agreed that we have both individual and collective goals and strategies. Our main goal is to improve Aboriginal women's health outcomes. Australia has not supported Aboriginal women to improve their health and well-being in meaningful ways, especially when compared to Western countries such as New Zealand, Canada and the United States. Many people on the ground report that they think that not only has Aboriginal health been not improving, it is actually going backwards. Many cite ongoing colonisation practices and current government attitudes and trends as a major cause of concern. There are also deeply racist and colonising attitudes that still permeate Australian society.

There are individual goals and strategies. Aboriginal women ask to be heard and their views respected. Health and education professionals are trying to find ways of putting theory into practice, to find ways to provide improved service delivery. At a very personal level, I am doing this evaluation as part of a PhD and this has been a negotiated outcome that began with me asking the Elder women for cultural consent to do this work, and receive academic recognition for it.

Our joint objectives are to support Aboriginal women to influence, inform, co-plan and co-evaluate their own health care. We hope to provide key stakeholders with opportunities to work collaboratively toward listening to, raising, discussing and responding to Aboriginal women's health needs. We also encourage culturally safe and respectful ways of working together.

The research/evaluation is located in a community campus site. This has a range of health and eduction services on one site. These include a mainstream community health service and a new Aboriginal health outreach centre, a primary school, kindergarten and childcare centre. There is also an Anglican Aboriginal Minster who lives at the manse on site.

Methodology and methods

When looking at what kind of methodology and methods to use in this evaluation, we reflected on what had come before. An older Aboriginal woman, Ros Pierce summed up the feelings of the reference group by saying ‘ Sis, the community has had enough of people coming in and doing surveys and research and then nothing happens and they never hear of it again. I think you had better work with them and make sure that something actually happens. Together we decided that participatory action research (PAR) as described by Ernie Stringer provides a very appropriate and supportive framework (Stringer 1999). This is continually being adapted to suit local Aboriginal and health service situations. We are continuing to discuss concepts of decolonisation as discussed by Linda Smith and participation as described Reason and Bradbury to see where they fit in relation to the complexities that surround us (Reason and Bradbury 2001; Smith 2003).

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PAR cycles of look, think and act have enabled both a grass roots collaboration and a consideration of organisational and policy trends. It has very strong links to comprehensive primary health care as described by the World Health Organisation (WHO 1978) and enabled practitioners to link theory to practice. It promotes the building of personal and community capacity and helped frame action towards sustainable outcomes. It is also a methodology favoured by many Aboriginal health researchers as it enables ethical consideration of important things such as reciprocity, respect, equality, survival and protection, responsibility and spirit and integrity. The NHMRC Aboriginal Health Research Ethics committee has highlighted these as being crucial to ethical research (NHMRC 2003).

In response, this evaluation has purposely included some very important steps. It began by the building of relationships and responding to invitation from community and health services to work together toward improved outcomes. An Aboriginal Reference Group was formed right from the beginning and guided the planning and implementation of this work. They will also be involved in thematic analysis and distribution of results. The PhD thesis will be read by the Elder women who will ensure that it does not contain private or cultural information that is not meant for public viewing. As a white woman, I could record or present cultural information that has wider ramifications that I am unaware of. We have created time be time and space to discuss these things together.

Ethical considerations

The ethics process has been both formal and informal. Formally, I have applied to four different ethics committees to gain approval for this research. At a local level I have spoken to health and education managers. I have also sought cultural permission to do this research from both Elders and women from nearby Aboriginal communities. A lengthy community consultation has been an important step toward building and maintaining relationships. I have spoken with community women, both Aboriginal and mainstream health services, schools and youth services, the Aboriginal health council who guides community controlled Aboriginal health services and a range of Aboriginal health researchers.

Following Ernie Stringer's advice (Stringer 1999), I worked to include all stake holder on and off campus in these discussions. These included a wide range of groups who had direct impact on, or who were impacted by Aboriginal women's health care.

These consultations and follow up discussion highlighted a range of challenges to Aboriginal women experiencing effective Aboriginal women's health and health care. Aboriginal women discussed societal issues of past and current colonising practices, negative health care experiences and daily acts of racism. Both community women and health service personnel highlighted short-term funding, high turn over of staff, organisational changes, skills shortage and difficulty putting theory into practice as major issues. Some of these are beginning to be addressed in South Australia through

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a range of implementation strategies at both a higher policy and local service delivery level.

Building trust

Aboriginal women have said that building collaborative and effective relationships is the first step in addressing issues. Trust is seen to be of utmost importance and this is supported in health research literature (NHMRC 2003). The women and I came up with an equation – time plus respect equals trust [time+ respect = trust]. For many Aboriginal women, trust and respect builds up over time. For some, trust is much more instinctive, a spiritual intuitive knowing, where they will either trust someone when they meet them, or they wont. I will now take time to discuss our ideas more deeply.

Time relates to recognising different peoples relationships to time and also finding time to work in respectful ways. This can be very difficult for workers meeting organisational timelines and funding obligations. There is also the consideration of timing, waiting until the timing is right, but also responding when the community are ready for interaction and action. There may be funerals and times of loss and grief associated with sorry business that requires programs to be delayed. There may also be situations where community need services to be provided before the health services are resourced and ready to provide them.

Respect often involves sitting and listening before jumping in with suggestions. Judy Atkinson discusses the importance of Dadirri, a deep non-judgemental listening with both the ears and the heart as described by Ungunmerr and the Ngangikurungkurr people of the Daly River area (Atkinson 2002). Aboriginal Elders in Adelaide similarly discuss connecting with both the head and the heart. Respect also involves recognising cultural differences, differing opinions, knowledge and ways of knowing and being open to two way learning about these things. The Elders ask us to connect with both our head and our heart, not to just come in with detached academic thinking or our own ideals. It is also important that relationships, evaluation and action be strengths based, focusing on strengths as well as issues. Aboriginal people say that they are tired of being told how sick and disadvantaged they are. They would like people to recognise their strengths and resiliency and the fact that they are true survivors. Similarly, health and education services ask evaluators and researchers to work with them, to recognise what they have been doing well. Action research needs to fit within the context, rather than being a stand-alone and unsustainable activity.

Trust is something that must be earned and re-earned. Like a friendship, it is not a one off event. The building and nurturing of trust relationships with community and key stakeholder is of utmost importance and should never be underestimated. It is like building bridges. I am positioned as both insider/outsider in relation to health service delivery, and also in some ways with some of the groups of women, introducing them to new workers and staff. I am a nurse researcher/evaluator, and in this community based study I cannot remove being a practitioner from being a researcher.

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Trust has been highlighted by many of the groups during the community consultation over the last eighteen months. The Elders stated clearly

> *'We don't mind you owning the research with us, but we don't want the university to own it. We know you, and you have earned the right. We trust you to do this right'.*
>
> *'We need you to write a readable thesis'.*

An Aboriginal manger expressed her concerns about how the research would be conducted and what the final outcome would be. She said

> *'I will support you and your research as long as you don't make things worse. I was once involved in research that led to good services being shut down because the researchers only saw one viewpoint'.*

Health staff and managers generally had concerns about whether the research would complement the work already being done. They said

> *'What ever you do, make sure you think about the ramifications for all of us. We have been working on this for a long time and some of the relationships and history is pretty complex. Remember timing'.*

Sharing our learning

One aspect of building trust has been to discuss and identify our personal and collective visions. We have discussed the balance between pragmatism and optimism that we need to work with what we have, but always believe that there can be more. Collaborative work has been seen to build capacity enormously. We have learned persistence, if at first you don't succeed, try and try again, but also take the time to check if you are on the right track, or if there are other considerations. This has been done following the Look, Think, Act cycles. Then look again (did it work) think again (reflect), and then act (have another try) as described by Stringer (1999). Importantly, we see the benefit in acknowledging the issues and barriers, but always working with people's strengths.

We have learnt a lot on our journey together, and I believe we will learn a lot more. So far we have sent he importance of negotiation and recognising the effect of power difference. The women discuss the importance of recognising the journey as well as the outcomes, of walking the talk. One woman described it so clearly by saying that in her group one cannot say that they are a great kangaroo hunter if they do not bring home a kangaroo.

Flexibility is a must in Aboriginal health and so to in research and evaluation. Evaluators need to be flexible to time, location and the setting of priorities. I found that different groups were most comfortable talking in different locations. Aboriginal women and I had the best conversations in the garden and the car park, very rarely in buildings. Health workers with their busy schedules spoke in their offices between phone calls, or over a quick cuppa. Sometimes we would get out from the buildings, away from the phones and into the sun. The actual physical moving seemed to help reflection at times, assisting people to see more clearly the complexity that they sit within.

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Recognising shared goals gave us a space to meet. It was often important to remember that we were all aiming for the same thing, improving Aboriginal women's health and well being, but that the way we went about doing this were often quite different. By working together, sharing our ideas and views over time, we came closer together and could collaborate more effectively.

We came up with some very practical ways forward. When faced with the huge mountain that is improving health for Aboriginal women in Australia in this century, we realised it was important to find ways to keep positive and keep going. Women spoke about keeping the fire in the belly stoked up, and the importance of helping omen to move from survival to really living. There are many ways of doing this and we will share some with you.

Recognising and celebrating resilience and survival is important. Sometimes community women are viewed by health and education services as troublemakers, people who disrupt the smooth running of programs. But this is also their strength and part of their survival, to push services to become more responsive to their and their families needs. It is important to believe in people, because they feel it deeply when you do not. Aboriginal people get enough negative portrayal in the media in Australia; they do not need it in interpersonal relationships as well.

It is important to celebrate in the little successes, the gems along the way. If we forget these, if we forget to celebrate, to recognise the achievements and build up our inner fires of hope, it all gets too hard and our inner fires go out. Aboriginal and non-Aboriginal people alike. These celebrations help people to move from survival to living a life more full. The celebrations may seem small and insignificant to some, but represent a mile stone for others. Community women negotiating the use of a room or resources at a community health service is one example. Being treated respectfully as a human being in social setting is another. Aboriginal women do not ask for the world, they just ask for a level playing field, to be given a fair chance.

Some women discussed specific visions that are important to them, which they keep in their minds as their goal. These might include Elders being able to live to be 80 years old, or for young women to grow up to be strong black women who know who they are and where they fit in their culture and wider society.

Where to from here?

From an evaluator/researcher and health practitioner position I keep asking myself, whose knowledge is valued in health, education and research? Do I, and do we in Australia really value Aboriginal women's knowledge and ways of knowing about themselves, their world and their health care, or do we only value western medical and academic knowledge and the negative media portrayals.

I do not present a conclusion, because there isn't one for us yet. Just as Australia is still colonising, this process is continually growing and developing to find ways to address the issues that exist. And so our journey continues as we continue to seek

ways of working together in culturally safe and respectful ways to improve Aboriginal women's health and well-being.

I will finish with the words of the Aboriginal Reference Group 'often whitefellas services do something once and think that it is done, but it is not a one off, it is an ongoing journey'.

Here's to finding new ways of working together in this new century while honouring the work that has been done by others around us and before us.

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