

Australian Indigenous Visions and Voices Enacted Through Research

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Abstract

Australian Aboriginal and Torres Strait Islander people visions and voices within the Community Controlled Health Sector in Queensland, Australia, are being embedded and enacted through the leadership and governance of the Queensland Aboriginal and Islander Health Council (QAIHC). QAIHC leads and governs the Australian National Health and Medical Research Council (NHMRC) Centre for Clinical Research Excellence (CCRE), which has a research and education focus on circulatory and associated conditions in urban Aboriginal and Torres Strait Islander communities. The establishment of the CCRE under the Community Controlled model of governance is unique and presents both opportunities and challenges for innovative partnerships between universities and Australian Aboriginal and Torres Strait Islander community organisations. It additionally presents the capacity to embed and enact Aboriginal and Torres Strait Islander visions and voices in education and research and to develop the capacity of Aboriginal and Torres Strait Islander people as researchers and educators.

Introduction

Carolyn Kenny outlines that, “Aboriginal research is research which reflects the values and beliefs of our peoples. Hopefully, when Aboriginal researchers do research, they will keep their thinking broad in terms of methods and approaches, and will, at the same time, be able to construct their research in a way which is in accordance with their worldviews” (2000:144). Kenny calls upon us to enact our rights as sovereign peoples within the realms of research. The enacting of our rights within the realms of research includes visioning and voicing what we think, what we need and what we want. It is from the visioning and sharing through voicing our visions that we can develop research processes that are about us as Indigenous peoples. This is how we can research best about who we are, what we do, how we think, our protocols and processes, and this is how we can represent ourselves best. Enacting our rights through research will also include challenging education systems, and the ontologies, axiologies and epistemologies within the research academy. In all of this we must challenge the hegemonies that maintain the status quo of the dominant culture and begin to put our own interests as Indigenous Australians first. The Queensland Aboriginal and Islander Health Council (QAIHC) as the peak body for the Aboriginal and Torres Strait Islander Community Controlled Health Sector in the Australian State of Queensland is most certainly placing Australian Aboriginal and Torres Strait Islander people and the sector it serves first.

Aboriginal and Torres Strait Islander Community Control of Research

Australian Aboriginal and Torres Strait Islander people within the Community Controlled Health Sector in Queensland are visioning and articulating through the leadership and governance of the Queensland Aboriginal and Islander Health Council (QAIHC). QAIHC is the peak body agency that represents Australian Aboriginal and Torres Strait Islander peoples in the community controlled health service sector in the State of Queensland, Australia. QAIHC is the State Affiliate of the National Aboriginal Community Controlled Health Organisation (NACCHO). QAIHC was established in 1990. Since its establishment, the number of Aboriginal and Torres Strait Islander Community Controlled Health Services (AICCCHS) in Queensland has grown from only a handful to 26 (2007). QAIHC also has significant partnership arrangements with other health related community controlled sectors in Queensland through the Aboriginal and Torres Strait Islander child protection services and alcohol and other drug organisations.

QAIHC leads and governs the Australian National Health and Medical Research Council (NHMRC) funded Centre for Clinical Research Excellence (CCRE) for Circulatory and Associated Conditions in Urban Aboriginal and Torres Strait Islander Communities. The CCRE research program focuses on the prevention and management of circulatory and associated diseases, such as heart and kidney disease, in Aboriginal and Torres Strait Islander peoples living in urban areas. Circulatory and related conditions are one of the major causes of excess morbidity and mortality in Aboriginal and Torres Strait Islander people in Australia. By housing the CCRE for Circulatory and Associated Conditions in Urban Aboriginal and Torres Strait Islander Communities with QAIHC, the research is more able to directly engage Aboriginal and Torres Strait Islander people as participants in the entire research process. This includes in the conceptualising, development, implementation and evaluation of projects.

Aboriginal and Torres Strait Islander people were instrumental in the formalisation of research processes and procedures of the CCRE, the development of specific research priorities and the pieces of research work that would be undertaken. This is explained in greater detail later in this paper. Essentially the CCRE has listened to the visions and is listening to the on-going voices about how the research projects would be conducted, who should conduct the research, and what are the health services' expectations of the CCRE. Enacting the visions and the voices of Aboriginal and Torres Strait Islander Health Service Sector occurs at a range of levels and results in members of the sector setting priorities for research, being engaged as research respondents, researchers, members of advisory committees and advocates and implements the research outcomes. The CCRE does work in partnership with a number of universities and the National Heart Foundation however it is the Aboriginal and Torres Strait Islander Community Controlled Service Sector that drives and leads the CCRE via QAIHC. The CCRE is placing the interests of Australian Aboriginal and Torres Strait Islander people within the Community Controlled Health Sector at the forefront in its research work. Aboriginal and Torres Strait Islander researchers use our knowledge, research training, abilities and skills, access to resources and the environment in which we work to work towards a vision for better health for our people in Australia

The governance structure and processes of the CCRE is underpinned by the operating values and principles of self-determination and community control. The principle of community control requires that ownership and governance of the CCRE is vested in Aboriginal and Torres Strait Islander people as reflected by the management and research strategies. The key partner institutions include Monash University, Queensland University of Technology, University of

Queensland, James Cook University, University of Wollongong, and the National Heart Foundation as well as the four participating health services. The four participating health services party to the CCRE include the Brisbane Aboriginal and Islander Aboriginal Community Health Service, Kambu Medical Service, Inala Indigenous Health Service and the Townsville Aboriginal and Islander Health Service. This does not mean that other research does not and will not take place with the other health services in the State of Queensland. The four mentioned were the four services named within the original NH&MRC CCRE application and are located in highly populated urban areas. A CCRE Executive Committee has been established and includes representatives from each partner institution; their role is to set the strategic direction of the CCRE Research Program. A CCRE Research Advisory Group (RAG) has also formed; their role comprises technical oversight of the development, implementation and evaluation of the CCRE Research Program. The establishment of the CCRE under the Community Controlled model of governance is unique and presents both opportunities and challenges for innovative partnerships between universities and Aboriginal and Torres Strait Islander community organisations. It is a process which does not just support Indigenous visions and / or voices but embeds them within the existence of such a research centre and research processes. The CCRE is extremely grateful to Leilani Pearce and Simone Nalatu for the work they did in the establishment phase of the CCRE. Leilani was the first Director of the CCRE, Simone Nalatu was the first Research Officer and Bronwyn Fredericks was the first Research Manager. It is through their commitment and energy that the CCRE vision was able to be realised. The CCRE staff list now includes Dallas Leon (Director), Audrey Deemal (Program Coordinator), Renee Blackman (Chronic Disease Coordinator), Tom Ogwang (Research Officer), Katie Panaretto (Public Health Medical Officer and Head of Population Health), Simone Nalatu (PhD Candidate) and Bronwyn Fredericks (Post-Doctoral Research Fellow).

The CCRE Research Program

The CCRE Research Program aligns with the NHMRC Roadmap (2002) to improve Aboriginal and Torres Strait Islander health through research with all research conducted under the major thematic areas:

- Descriptive research that outlines the pattern of risk, disease and death as it related to circulatory disease in urban populations
- Identifying points in the life cycle when interventions are likely to be most effective and the life skills and knowledge needed for this
- Health services research that will inform decision-making in relation to practice and funding for health services
- Research that will improve outcomes in relation to circulatory disease in Indigenous communities through other sector initiatives.

The CCRE Research Program has four Program Areas that interconnect with the Roadmap's thematic areas. These are:

1. Improving the prevention and management of circulatory and associated conditions
2. Improving access to health services and programs
3. Health system development and reform
4. Building capacity and enabling health research

In May 2005 a planning workshop was conducted at Mt Tamborine in the Gold Coast hinterland which brought together all of the key stakeholders involved in the CCRE. This marked the first occasion that the QAIHC Executive and CEO, all Chief Investigators, most Associate Investigators and representatives from each of the participating health services met face-to-face. The purpose of the workshop was to hold a series of discussions in order to set short, medium and long-term priorities that needed to be achieved to ensure the success of the CCRE. At the conclusion of the planning workshop a work plan was produced which expanded all elements of the research program that was outlined in the original grant application. Since this there have been other meetings, including another large workshop in 2006, which again brought together the QAIHC Executive, CEO, Chief Investigators, most Associate Investigators and representatives from each of the participating health services. CCRE staff members were at that workshop which was to review the Research Program and focus on any other priorities and areas where there may have been gaps.

Throughout the CCRE development process the partners have had a commitment to working in a way where all participants contribute and benefit. This CCRE model can be best described as a community-based participatory action research. In a community-based action research process, the research begins with working with a group, community or organisation in defining the problems, situations, issues and then involves working with the group, community or organisation in the process towards change, finding solutions or answers (Glesne, 1990; Stringer, 1996). Wadsworth, in writing of action research, describes it as ‘participatory’, that is, people need to participate to make it happen (1997: 61). Participatory research according to Lukabyo, is usually developed with “the purpose of empowering community people to find solutions to community problems” (1995: 4). Participatory action research therefore has the capacity to provide a notion of community development, social justice and empowerment. It can additionally encapsulate elements of political awareness and political action connected to better health if designed this way.

After careful consideration of a range of methods, QAIHC believed that it would be possible to engage several approaches from methodologies known as community-based action research and participatory research (often used inter-changeably) and with elements of reflexivity and / or introspection along with the principles of Indigenist methodology as outlined by Rigney (1997, 1999). Rigney (1997: 2) suggests principles as a, “step toward assisting Indigenous theorists and practitioners to determine what might be an appropriate response to de-legitimise racist oppression in research and shift to a more empowering and self-determining outcome” (1997: 2). He outlines the need for simultaneous engagement within research and the political struggle for Aboriginal and Torres Strait Islander peoples and asserts “that “Only in this way can research responsibly serve and inform the political liberation struggle” (1997, p.2). Rigney’s work builds on the work of Warrior who has stressed the need for Indigenous intellectual sovereignty (1995, 1999). Warrior outlines that sovereignty is the path to freedom via a process of emergence for Indigenous peoples, as a group or collective (1995: 91). He provides direction that intellectual sovereignty is a process; it is not about outcome (1995: 91). It is about the speaking, reflecting and articulation through a range of means about the Indigenous struggle and what strategies to freedom are needed. Rigney in his interpretation of Warrior’s writings outlines that, “If Indigenous intellectual sovereignty is to be emancipatory it must be ‘process driven’ rather than outcome oriented...it is now for Indigenous scholars committed to sovereignty to realise that we

too must struggle for intellectual sovereignty and allow for the definition and articulation of what that means to emerge as we critically reflect on our struggle” (2001:10). With Rigney’s words in mind, the CCRE is well positioned to research responsibly and to serve and inform the struggle for better health for Aboriginal and Torres Strait Islander peoples. There is a direct link between research and the political struggle of Indigenous communities and the direct link is in and through Indigenous peoples who are simultaneously engaged in research and the Indigenous struggle. The CCRE and QAIHC is doing this through their over arching research approach that could be regarded as Indigenous / Indigenist participatory community-based action research. This process has enabled QAIHC to work within an Indigenous context engaging both the Community Controlled Health Sector and the higher education sector. Furthermore, this approach additionally allows for other methodologies to be incorporated pending specific projects and issues.

CCRE Research Principles

The CCRE Research Principles were developed and designed as a guide for researchers wishing to undertake projects and study within the CCRE and the Community Controlled Health Services Sector in Queensland. They are based on the NHMRC Criteria for Health and Medical Research of Aboriginal and Torres Strait Islander Australians, which are:

- Community engagement and participation
- Benefits
- Sustainability and transferability
- Capacity building
- Priority and significance

The CCRE Research Principles require any research project to be based on:

Identified Need – Research projects must be in response to identified community and Health Service needs and priorities. Having the Health Service involved in the development of the full project brief will assist this process as the respective Board of Management needs to endorse any research projects undertaken.

Action Oriented – Research projects must contribute to change within the health service and demonstrate benefit to the community. Outcomes need to be direct and tangible – for example, funding, human resource management, education and training, clinical practice, workforce development and planning, building the evidence base, community development, and capacity building.

Skills / Knowledge Transfer – The methodology of research projects should reflect Aboriginal and Torres Strait Islander people’s involvement at all levels of the research project. A clear strategy for knowledge and skills transfer should be an explicit component of any research project. Skills and knowledge transfer strategies should be agreed to with the Health Service at the start of the project.

Acknowledgement – research projects must explicitly recognise the contributions of individuals, community groups, and Health Services in the research process.

Consultation - The research project must have appropriate consultation strategies in place to ensure that the information collected is interpreted in a true and accurate way. Within local Aboriginal and Torres Strait Islander communities and Health Services there are existing processes for consultation and engagement.

These consultation strategies should occur at the critical stages of a research project, including:

- initial engagement in the research project (telling people about the project brief and confirming support for the project)
- agreement on strategies for consultation, information collection, and working with the Health Service and community
- the feedback processes that will be put in place for verification of the information collected
- acknowledgement of the individual(s) and Community Controlled Health Service's involvement in reports, materials, publications etc resulting from the research project.
- agreed mechanisms in place for disseminating information and translating skills and information.

Aboriginal and Torres Strait Islander ownership of information – recognition that information and data collected or related to the Aboriginal and Torres Strait Islander community is owned by the community. Therefore decisions about the way in which this information is to be used and interpretations need to be agreed to by the community.

Aboriginal and Torres Strait Islander Ways of Working – recognition and demonstrable support in the research project for Aboriginal and Torres Strait Islander ways of working as culturally valid and valued in research input, output, and outcomes. This means that there is also recognition of diversity between Aboriginal and Torres Strait Islander people and communities.

Community Control – Community control of health is the fundamental premise on which Aboriginal and Torres Strait Islander Community Controlled Health Services developed. These services are initiated by their local Aboriginal and/or Torres Strait Islander community to provide high quality, culturally appropriate comprehensive primary health care.

Conclusion

Wheaton explains that “Many academics refuse to acknowledge that Aboriginal people’s existence and conceptions of themselves are very different from their own. Objectification does not convey a “true” picture of anyone; objectification, in fact, creates a false image of Aboriginal people, more like a caricature than a portrait. If Aboriginal people determine how the picture of them should be created, and with what materials and techniques, the final composition will more accurately depict Aboriginal people and the vitality of their lives” (Wheaton, 2000:156).

Wheaton argues for the need for Indigenous peoples to challenge the systems, ontologies, axiologies and epistemologies within the research academy; and for the need for Indigenous peoples to develop research processes that are about us as Indigenous peoples in order to represent us best. There is without doubt a need for Indigenous research processes that reflect who we are, what we do, how we think, our protocols and processes, in order to represent us best. I believe we need to be resourceful and think deeply about what we mean when we talk about

Indigenous research and Indigenous research processes. We have a difficult task ahead of us in how we develop and articulate Indigenous research methodologies and an even more difficult task ahead when we begin to push collectively for the implementation of various Indigenous research ways within a higher education system that is highly racial, colonial and imperialistic and when the word research itself is “probably one of the dirtiest words in the indigenous world’s vocabulary (Smith, 1999:1). What QAIHC has done in establishing the CCRE is establish a place where we can dream, vision, voice and enact strategies for emancipation, liberation, subjectivity and resistance, and where we can individually and jointly speak as a collective. As Indigenous peoples we do not remain voiceless and marginal within the CCRE and QAIHC. The Indigenous people who had the vision for the CCRE have created a path for Indigenous people for now and the future. They were able to see that “Aboriginal research is an opportunity for us to create innovation and change for our people. If we develop an approach to research which is unique and reflects our values and beliefs, we will be reflecting the spirit of our ancestors, the spirit of our people who are alive today, and the spirit of our Aboriginal children who are yet to be born” (Kenny, 2000:148).

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