Co-design with aboriginal and torres strait islander communities: A journey

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Abstract

Aim: This paper explores the principles of co-design with Aboriginal and Torres Strait Islander communities by reflecting on the literature, learning from experiences of allied health professionals, and considering how co-design can be applied in rural and remote allied health practice.

Context: This paper has been authored by a working group from Services for Rural and Remote Allied Health (SARRAH). SARRAH is a member-based allied health organisation, working to improve health outcomes for rural and remote Australians. SARRAH has been representing and supporting allied health professionals in rural and remote Australia for over 20 years, with a member base that includes students, practitioners, programme managers, policy makers and academics. As a non-Indigenous organisation, SARRAH works in partnership and receives guidance from the peak organisation, Indigenous Allied Health Australia (IAHA).

Approach: Over a period of 3 months, a group of eleven SARRAH members and staff came together to review available literature, seek member perspectives and share their experiences and understandings of co-design. Working group discussions were grounded in the knowledge and experiences shared by two Aboriginal and Torres Strait Islander group members.

Conclusion: This paper proposes that successful co-design with Aboriginal and Torres Strait Islander communities places legitimate value on different knowledge systems, is built on strong and trusting relationships, promotes inclusive involvement and requires authentic partnerships. Using these principles, SARRAH will engage with members and stakeholders to influence meaningful change in allied health practice in rural and remote Australia.

KEYWORDS
authentic partnerships, community-led, definition of health, rural and remote allied health, the third space

1 | TWO TRACKS

As a proud Aboriginal and Torres Strait Islander man, my experience of co-design has typically been from the 'other' perspective. As a young boy and into my adolescence, I was not in the position to have a voice. The stereotypes and unconscious bias that people had of First Nations students did not afford me any authority on anything, including myself. Others thought they knew what I thought, what I wanted and what I needed. When we were asked about how we thought things should be, it was done in a tokenistic manner so a box could be ticked to say we were 'consulted'.

As I grew and understood more of the world in which I existed, I learned about privilege and power and how I was never afforded either. Throughout my studies at university, my people were also exemplified as case studies of failure: poor health outcomes, poor health service engagement and poor understanding of systems. I knew from experience that I wasn't the problem in the system; the system had not been designed for me. I knew this because as a 14-year-old, I became critically ill with bacterial meningitis. Things were done to me over which I had no control. Stuck in ICU and then general wards for 8 weeks, I never saw my family, a First Nations practitioner or anyone who really could empathise with me. I was scared and culturally unsafe. My health was medicalised with no attention directed towards my well-being. It is my reflections of this traumatic time that determined my path. There had to be a better way of working.

Throughout my studies, I was never taught about Aboriginal and Torres Strait Islander ways of working. Everything was taught through the lens of the Western dominant culture. Methodologies of shared understanding, shared goals and cultural safety were not described in a way that resonated with me. At the same time this was occurring, I established a consulting business with a white woman who had been my teacher, tutor and friend since I was fourteen. The focus of our work is to create learning environments where Aboriginal and Torres Strait Islander students can thrive. However, to do

What this paper adds:
- Understanding of co-design in the lived experiences of allied health in remote and rural communities
- Recommendations at the organisation level of best practice co-design in rural and remote allied health context

What is already known on this subject:
- There is a scarcity of literature about co-design in rural and remote allied health practice
- There are examples of successful co-design programmes that have been led by Aboriginal and Torres Strait Islander communities
- In the policy space, co-design is often interpreted as participatory and inclusive of, rather than led by the community

this we centre and privilege the voices of First Nations students and their families. Using grounded theory methodologies, we build our work around their perspectives, their lived experiences, their hopes and dreams for their children and themselves. The workshops that we build together are contextualised to each specific school. They are not about embedding Indigenous perspectives into the curriculum. They hold a mirror up to the school and ask them to describe what they see and feel in relation to the education of their First Nations students.

An analogy that describes my understanding of co-design is a railway track, with Western knowledge systems on one side and First Nations knowledge systems on the other. Both sides have their own protocols, definitions of health and methods for storing, transmitting and translating information. Not all knowledge is accessible nor should be shared. This is critical to the upholding of cultural practices, designating certain people in each community as holders of information and knowledge. The railway is only effective because the rails are kept at an equal distance from each other by the sleepers. Sleepers are constructed as stabilisers. They keep each side in their own lane. For each side to work together, there needs to be sleepers. These sleepers define each other's use of language: definitions of health, who has

control of health data, how that health data are stored. The sleepers are what I see as the component of co-design. Without acceptance and understanding of each side's knowledge, the track gets warped.

Nathaniel Tamwoy

2 | OUR JOURNEY

In response to the call for papers for this special edition of the journal, SARRAH sought participation from members who had an interest in co-design within the context of allied health practice in rural and remote Aboriginal and Torres Strait Islander communities. A writing group was established, comprising eleven SARRAH members and staff. The group included experienced academics and researchers in their field, early-career academics and clinicians who were new to publishing, from most states and territories in Australia. Two members of the group are Aboriginal and Torres Strait Islander people who took leadership roles within the writing process. Indigenous Allied Health Australia (IAHA) provided guidance to the group through reviewing drafts and providing critical comment.

Over a 3-month period, meetings were held weekly via video conference to review and critique the literature, discuss lived experiences of co-design, and consider the application of co-design in rural and remote allied health practice. The regular discussions helped to develop a level of trust and cultural safety, where group members could unpack their experiences, discuss the issues of power and privilege within the health system and facilitate critical thinking on the issues. All group participants contributed to the concept development and writing of the paper.

In an early discussion among the group, Nathaniel Tamwoy shared his personal reflections as an Aboriginal and Torres Strait Islander man on co-design, and it was this experience that anchored and shaped the ongoing discussions with the group.

In this paper, SARRAH shares these learnings and makes recommendations for rural and remote allied health practice.

3 | WHAT DID WE LEARN?

Through review of the literature, reflecting on lived experience and seeking member feedback, the group established four key themes:

- Co-design values different knowledge systems
- Co-design is built on strong and trusting relationships

- Co-design requires authentic partnerships
- Co-design operates in between the 'tracks'

3.1 | Co-design values different knowledge systems

There is no single word or expression equivalent to 'health' in Aboriginal and Torres Strait Islander languages, with health and well-being conceptualised more broadly.[1] According to the National Aboriginal Health Strategy:

> Health to Aboriginal peoples is a matter of determining all aspects of their life, including control over the physical environment, of dignity, of community self-esteem and of justice. It is not merely a matter of the provision of doctors, hospital, medicines or the absence of disease and incapacity. ([2] p9); and

> Health is not just physical well-being of the individual but the social, emotional and cultural well-being of the whole community. This is a whole-of-life view, which includes the cyclical concept of life–death–life. ([2] p10)

These holistic perceptions of health challenge the biomedical and biopsychosocial models of health, which inform health education and practice in Australia.[3] Mainstream health policy and services that focus on the individual over the collective, promote autonomy over social connection and can be incongruent with Aboriginal and Torres Strait Islander social and cultural determinants of health.[1] Co-design with Aboriginal and Torres Strait Islander communities requires Aboriginal and Torres Strait Islander worldviews and knowledges about health and well-being to be placed at the centre, culture to be recognised as a fundamental enabler and communities, families and individuals acknowledged to have authority and expertise about themselves.[4] It is also crucial to consider the ongoing impact of colonisation, power inequities, racism and unconscious bias on the health of Aboriginal and Torres Strait Islander peoples.[5]

Meaningful co-design partnerships with Aboriginal and Torres Strait Islander communities happen when health professionals are enabled to place equal or greater value on a community's culture(s), knowledge systems and ways of working.[6] Aboriginal and Torres Strait Islander community-controlled organisations which privilege local ways of thinking, doing and being are inherently more suited to leading co-design. Ngaanyatjarra Pitjantjatjara

Yankunytjatjara (NPY) Women's Council echo Nathaniel's railway track analogy in their *Workforce development and capability framework*:

> NPY Women's Council operates with the understanding that employees ensure there is an ongoing exchange of knowledge and skills. Western knowledge, which provides the basis of professional disciplines such as social work, nutrition science, youth work, management and so on, is not in a hierarchical relationship with the cultural and contextual knowledge of the NPY Lands and Anangu. They exist side by side, and practitioners of all backgrounds must engage in a process of both ways learning so that these different knowledges and perspectives are combined to develop new knowledge and perspectives that is then incorporated into the work of the organisation.[7]

3.2 | Co-design is built on strong and trusting relationships

Successful co-design relies on interconnected relationships between allied health professionals and Aboriginal and Torres Strait Islander Peoples, communities and organisations.[4] People and communities need time to get to know and trust allied health practitioners before sharing community goals, hopes and aspirations.[8] Practitioners need to create time and space to enable the voices of those who access allied health services to be heard and understood. The IAHA Cultural Safety Framework describes the importance of listening deeply, learning from community members, practising self-reflection and consciously realigning practices to suit the community way of being.[9]

Co-design requires dedicated time for yarning, sharing stories and honouring lived experiences of community members. The Uti Kulintjaku Watiku Project,[10] led by Anangu women from across the Anangu Pitjantjatjara Yankunytjatjara (APY) lands, continually developed and created spaces for Anangu to think deeply, learn, tell stories and share ideas about social and emotional well-being. Co-design workshops encouraged reciprocity in teaching and learning between Anangu and Western trained professionals, resulting in trust, respect and transformative change for communities.

3.3 | Co-design requires authentic partnerships

To ensure an effective co-design process, NSW Council of Social Services (NCOSS) identifies five key principles,

which must be considered between partners from the outset. Any co-design process should be inclusive, respectful, participative, iterative and outcomes focused.[11] SARRAH concurs that these principles can be the drivers for establishing authentic partnerships that positively influence allied health service delivery with and for Aboriginal and Torres Strait Islander communities. Similarly, the IAHA Cultural Responsiveness in Action Framework[9] describes how clinicians can ensure cultural safety when working in Aboriginal and Torres Strait Islander communities, including for purposes such as co-design. The pillars of this Framework include respect for centrality of cultures, self-awareness, proactivity, inclusive engagement, leadership, responsibility and accountability.

Authentic partnerships have the potential to positively influence health service design and subsequent health outcomes. According to Rudman and colleagues,[12] it is important that clinicians possess humility, inquisitiveness and openness to dismantle existing power relationships. Partnerships also require the right mix of people from both sides of the 'tracks'. Community First Development (CFD) describes the idea of building partnerships through 'right way governance', which involves practitioners '*sitting in the passenger seat and navigating through systems and stakeholders while communities drive and take the lead*'.[8] In an allied health context, to establish a co-design partnership, non-Indigenous clinicians are encouraged to recognise their relative positions of power, privilege and unconscious bias when working in settings with Aboriginal and Torres Strait Islander Peoples. An allied health professional will be required to work according to the cultural guidelines of a given community, rather than adopting a one-size-fits-all practice approach.

Connections to culture, country and language are fundamental to co-design. For example, if an allied health professional is working in community, then the community will have their own ways of working and connecting:

> In Badu Island culture, there is a concept known as Koeyma Mulaka. When people move away and come back to community, there is a time of reconnection. When two people reconnect, they start at the bottom, at the lowest level of their relationship. They are the same. There is no power differential. People meet together as equals. This is a true 'balance of power'.
>
> Nathaniel Tamwoy

3.4 | Co-design operates in between the 'tracks'

Successful co-design needs optimal conditions for inclusivity.[13] This includes time and resources, support for

those involved, development of relationships and shared values, and the redressing of power differentials. A 'space' is required where all parties can come together for true engagement. In emerging research in Aboriginal and Torres Strait Islander governance this has been labelled the *Third Space*.[14] Nathaniel envisages this space as working on the sleepers between the railway tracks of knowledge, Sundbery and Latham[15] describe NPY Women's council use of the concepts of Malparara, a friendship where outcomes are strengthened through working together side by side; and Ngapartji Ngapartji meaning means to reciprocate, to give and take for the mutual benefit of those engaging in a shared activity. Optimal conditions are more likely to occur when community Elders, members and/or community-controlled organisations are leading.[16]

Working in this space requires non-Indigenous, and non-local Aboriginal and Torres Strait Islander allied health practitioners, to be comfortable with discomfort. It is important to be aware of and relinquish the power associated with being a health professional and take on the mindset of a learner, acknowledging how much there is to learn. Being open to uncertainty, not knowing, and making mistakes takes courage and is fundamental to working in partnership with Aboriginal and Torres Strait Islander communities.[12] Without true inclusive involvement in the Third Space, processes should not be considered as co-design, as the power differential cannot be eliminated. Rather, these should be recognised as possible consultations or potentially, (at most), collaborations.[8]

4 | THE FUTURE—A JOURNEY, NOT A DESTINATION

Co-design is a journey for individuals, teams, communities and organisations.[11] It takes changes in personal capacity, organisational mindset and policy for the system to engage authentically with Aboriginal and Torres Strait Islander Peoples. The lived experiences of Aboriginal and Torres Strait Islander people, families and communities continue to be impacted by the ongoing effects of colonialisation. Notwithstanding the value of strengths-based approaches, these impacts are perpetuated by contemporary policy settings and health systems.[17] The role of health professionals in upholding these systems in practice needs to be regularly and purposefully examined. Acknowledgement of, and reflection on, past issues should underpin co-design processes.

The journey for SARRAH and other non-Indigenous organisations has two important facets. The first is to ensure that the organisation and its people move into the Third Space, to work with Aboriginal and Torres Strait Islander organisations to define goals, to mobilise resources and to develop action plans.[18] The second is to sustain authentic partnerships, with IAHA, ACCHOs and other Aboriginal and Torres Strait Islander organisations. The organisation's ways of working need to be reoriented to ensure new initiatives do not have predetermined outcomes or deliverables and to recognise the time and resources required to undertake a meaningful co-design process.

5 | THE NEXT GENERATION WILL LEAD THE WAY

> As an Aboriginal and Torres Strait Islander allied health professional, my responsibility sits in creating change in how people listen, how people engage, how people are taught, and how people reflect. For this to occur, the current generation of educators, researchers and lecturers need to undertake the co-design process with the new, critically thinking generation of practitioners who are agitating for change in systems globally. Until that dominant culture way of working is deconstructed, Aboriginal and Torres Strait Islander peoples will continue to be seen as products of their own making.
>
> Nathaniel Tamwoy.

The next generation of allied health professionals is beginning to move into leadership spaces, and greater numbers of Aboriginal and Torres Strait Islander health professionals are joining the professions.[19] This new cohort of allied health professionals has the opportunity to act as agents of social and political change, working to build personal, cultural and academic insight among themselves and others in positions of privilege, and mobilising in collective action under the leadership of people and communities.[20] To facilitate this transformation, universities and other academic institutions must adopt a decolonising agenda within allied health curricula to respond to the inequalities in the system. The education and training of future allied health professionals must be inclusive of the many different cultures and understandings of health and community and recognise the privilege currently afforded to the dominant Australian culture.[11] All students of allied health must be able to recognise themselves and their cultures in their studies, rather than as being perceived as case studies of failure, as Nathaniel reported.

6 | FINAL WORDS

Shaping the future of rural and remote allied health workforce and service design will require allied health

professionals to step away from their comfort zones, to set aside any perceptions of power that university qualifications and credentials may invite and to recognise and be guided by the expertise and sovereignty of Aboriginal and Torres Strait Islander colleagues. As fellow travellers on the journey that is co-design, SARRAH must continue to work with IAHA, as the experts in allied health service delivery to Aboriginal and Torres Strait Islander Peoples through our shared Memorandum of Understanding, to find ways to support allied health professionals to appreciate that in order to redesign fit-for-purpose health services, we must first consider redesigning ourselves.

AUTHOR CONTRIBUTIONS

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CONFLICT OF INTEREST

None declared.

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No ethics approval was required for htis article.

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