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Conceptualizing the association between community participation and CQI in Aboriginal and Torres Strait Islander PHC services

Abstract

Drawing from Australian Aboriginal and Torres Strait Islander (hereafter-termed Indigenous) perspectives we conceptualise the association between community participation and continuous quality improvement (CQI) processes in Indigenous primary health care (PHC) services. Indigenous experiences of community participation were drawn from our study identifying contextual factors affecting CQI processes in high improving PHC services. Using case study design, we collected quantitative and qualitative data at the micro-, meso-, and macro-health system level in 2014 and 2015 in six services in northern Australia. Analysing qualitative data, we found community participation was an important contextual factor in five of the six services. Embedded in cultural foundations, cultural rules, and expectations, community participation involved interacting elements of trusting relationships in metaphorically safe spaces, and reciprocated learning about each other's perspectives. Foregrounding Indigenous perspectives on community participation might assist more effective participatory processes in Indigenous PHC including in CQI processes.

Key words: Australia; Indigenous; Aboriginal and Torres Strait Islander; community participation; primary health care; continuous quality improvement.

Introduction

There are calls for Indigenous communities to become active partners in their health delivery (Sherwood 2013). Community participation is thought to build a better understanding of community needs and priorities (McCalman et al., 2018), build expectations for quality care, and strengthen community leadership for health (Wise, Angus, Harris, & Parker, 2013).

Foregrounding Indigenous perspectives (Acton, Salter, Lenoy, & Stevenson 2017) enables effective participation and partnerships through providing an opportunity for conceptual and social learning for the non-Indigenous workforce working in CQI (Wise, et al. 2013). In this article we draw on the perspectives of Indigenous researchers and participants to conceptualise the association between community participation and quality improvement in response to Continuous Quality Improvement (CQI) processes in Indigenous primary health care (PHC) services in northern Australia.

The contribution of, and relationship with, the Indigenous communities in which PHC services are embedded is a contextual factor being examined in Indigenous CQI initiatives in Australia. While community participation in Indigenous CQI is promoted (Bailie J., Laycock, Matthews, & Bailie R. 2016), there is not a clear pathway forward. Different epistemologies about 'participation' (Taylor 2015), different perspectives on the value of local knowledge (Eversole, 2012), a lack of resourcing for the processes of collective community level action (Carlisle, Farmer, Taylor, Larkins, & Evans, 2018; Waring, Allen, Braithwaite, & Sandall, 2016), and the lack of Indigenous participants' narratives about aspects of participation (Champion, Franks, & Taylor, 2008), are limiting factors.

There is no one theoretical base for community participation (Farmer, Taylor, Stewart, & Kenny, 2017). In a systematic review of Australian Indigenous community participation in health and community development, Snijer, Shakeshaft, Wagemakers, Stephens, & Calabria (2018) used a framework of six levels of community participation to assess literature; passive participation, participation by information, participation by consultation, functional participation as involvement without decision-making, interactive decision-making, and self-mobilisation. Consultation and information giving are often practiced without a theoretical base. Various theoretical approaches underpin the more active levels, for example empowerment theory (Fawcett, et al. 1995), community organization theory (Minkler 2012) and theories of social capital (Portes 1998).

Australian Indigenous concepts about community participation are becoming increasingly influential, for example the work on community development by Kickett-Tucker, with Bessarab, Coffin, and Wright (2017). From an Indigenous perspective, processes that might be termed ‘community participation’ are culturally expressed, and often about health as an overall component of community development (Sherwood 1999). One example, and there are many, is the Aboriginal Community Controlled Health Services (ACCHS) movement. These are PHC services initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community that controls it through a locally elected Board of Management (www.naccho.org.au). Community control and community and health development are seen as inter-twined and inseparable (Houson 2004; Sherwood; 1999 Sherwood & Geia 2014).

Contrasted with this, in many other parts of the health system, particularly in government health authorities, there is an instrumental approach to community participation in CQI as discrete activities undertaken generally at the behest of health professionals. This approach is consistent with the strategic separation and control of programs where health improvements are made through specific interventions that have clear measurable outcomes (Storeng & Béhague 2014). Sometimes community participation interventions are ‘travelling models’ transposed from very different contexts with minimal adaptation (Olivier de Sardan, Diarra, & Moha, 2017). The instrumental approach to community participation works well in situations where there is consensus about what needs to be done to improve healthcare and there is an accessible evidence-base. Usually though, community participation is most effective in Indigenous health improvement where communities are using their cultural power with health professionals using their clinical expertise and a “‘decolonising gaze’ that reflects upon the political and historical events that have impacted on Indigenous Australians” (Sherwood 2013 p. 28).

Recently there have been some successes in improving health outcomes for Indigenous Australians. There have been significant declines in mortality rates for all Indigenous Australians and in children 0-4 years according to the Aboriginal and Torres Strait Islander

Health Performance Framework Report (Australian Health Ministers' Advisory Council, 2017). One strategy to achieve these gains has been to strengthen adherence to best practice guidelines of PHC delivered to Indigenous people using CQI initiatives. The CQI paradigm in Australia is a systematic approach to improve intermediate health outcomes using regular reflection and refinement to improve processes and outcomes (Wise et al. 2013). The paradigm includes a Plan, Do, Study, Act cycle (Gardner, et al., 2011) and the incorporation of 'whole of health system' thinking and action (Braithwaite, et al. 2016).

A group of Indigenous communities, health services, policy makers, academics, and health professionals are working together in an innovation platform around CQI: the Centre for Research Excellence in Integrated Quality Improvement (CRE-IQI) (Schierhout, et al. 2013). In association with this program of work (and its predecessor the ABCD National Research Partnership), some gains in quality of care have occurred in chronic illness care and maternal and child health care (Bailie R., Matthews, Brands, & Schierhout, 2013; Gardner, Dowden, Togni, & Bailie R., 2010; Gibson-Helm, et al. 2016). There are however, variations in effectiveness of CQI interventions across services with little information about what contextual factors contribute to this variation (Gardner et al., 2011; Matthews, et al., 2014; Schierhout et al., 2013). This is to be expected given the difficulty of identifying and then measuring the modifying effects in different situations (Brennan, Bosch, Buchan, & Green, 2012). Inevitably, there is a struggle in understanding, conceptualising, and then integrating the influence of contextual factors, such as the community history (Edwards & Sherwood, 2006), role of culture (Bond & Brough, 2007), or social exclusion (Baker, 2010) in quality improvement frameworks (Stoopendaal & Bal, 2013).

Study background

Understanding contextual factors that might influence CQI was the goal of our study conducted in collaboration with six Aboriginal or Torres Strait Islander PHC services. These services were successful in improving the quality of care provided in response to CQI programs. We explored: i) the relationship between the contextual factors and CQI improvements in these services; and ii) the services involved translating these findings to other services so there might be mutual learning.

The six services were located in northern Australia; a vast area including north Queensland, the Torres Strait, the North West and Kimberley region of Western Australia, and the Northern Territory - almost one third of the Australian continent (Table 1). In the Northern Territory, most of which is in northern Australia, 25% of the population is Aboriginal and Torres Strait Islander (Australian Bureau of Statistics 2016). Most of northern Australia is classified as remote or very remote with the islands of the Torres Strait lying between the tip of the Australian mainland and New Guinea extending approximately 200 to 300 km from farthest east to farthest west. There are vastly different levels of access to primary health care facilities in these remote areas (Reeve, et al., 2015). In northern Australia, three state/territory jurisdictions have implemented quality improvement strategies differently, using different tools and with very different levels of resourcing (Gardner et al. 2010). There is a mix of governance arrangements for services with some ACCHS and state or territory provided care as well as for profit general practices. This diversity provided an opportunity to examine CQI elements for their importance in these disparate services and locations at three levels of the health system, the macro-, meso-, and micro-levels.

Table 1 Case study sites to be inserted here

Methodology

The study used health systems concepts to describe the Indigenous PHC services as systems with interacting macro-, meso-, and micro-levels (Caldwell & Mays 2012).

Case study design and selection

A multi-case comparative case study design collecting quantitative and qualitative data was employed. We report here on the methods associated with the qualitative interview data co-generated with health personnel and service users in these high improving primary health care services. Cases were selected on the basis of improving quality of care indices for

Indigenous health services participating in a research partnership. These indices were based on the delivery of services against the recommended guidelines for service provision in at least two of four possible areas: maternal health, child health, preventive health and chronic disease (Type 2 diabetes T2DM) over a minimum of two cycles (three audits). (Larkins, et al., 2016)

Recruitment; data collection; field visits

At each of the services information about the study was provided and clinicians, including Aboriginal Health Practitioners, and management/administration staff were approached for an interview. Clinicians who visited the location on a regular basis and regional management staff were also approached. In total, interviews were held with 132 people (Table 2). In pairs, one Indigenous and four non-Indigenous interviewers not associated with the health centres conducted the interviews. Interviewers travelled at least twice to each of the remote services to conduct face-to-face digitally recorded interviews. Sixty-six health service personnel (including 15 Indigenous personnel) were interviewed and 66 service users (including 54 Indigenous service users). Questions to health personnel included how CQI was undertaken, the service workforce, how improvements in health care are made, information management, and perceptions about why the service might be improving so much. Service users were asked about their history of contact with the service, how they found the staff and their health care, and their perceptions of the reasons why the service was high improving.

Table 2 Interview participants to be inserted here

Ethics and consent

Human research ethics approval was obtained from one university and four state or territory health ethics committees including an Aboriginal/Torres Strait Islander ethics committee.

Data analysis and knowledge translation

Interviews were transcribed and read by four team members and analysed abductively (Timmermans & Tavory 2012), to produce concepts. We used a process of building concepts from the case studies consistent with Eisenhardt’s (1989) approach. First, broad coding categories were devised for service users and another set for health service personnel or regional managers. Then each interview was coded deductively case-by-case initially by two researchers according to the interview questions, using the same codes across cases where possible. Coding was checked for consistency by these two researchers. NVivo qualitative data analysis software (QSR International Pty Ltd. Version 11) was used to manage data. Within-case themes were developed inductively identifying underlying meanings apparent in codes. These themes were reported back to participants during visits to case study sites as part of the participant validation process. Each case's themes (uniquely expressed) were displayed as a matrix and similarities and differences across cases identified. Then workshops with representatives from each site, stakeholders, and researchers discussed the analysis and preliminary findings to confirm representativeness and to enable findings to be used in the service. Finally an overall set of themes was explored creatively using the extensive literature-base about community participation with particular focus on that written by Australian Indigenous scholars or practitioners. One team member, an Aboriginal Anmatyerre/ Jaru woman, provided her perspective which was integrated with the knowledge from other Indigenous scholars who had developed relevant theories and concepts. The Indigenous concept to enhance that of community participation has been discussed at seminars and with other services interested in improving their practice.

Findings

The findings presented here describe the ways in which the Indigenous communities participated in aspects of health development that positively affected CQI processes. Activities were apparent and entwined at the micro-, meso-, and macro-health systems levels and generally in partnership with health professionals. The communities participated differently, some more extensively than others. Communities associated with the five services were involved in identifying health care issues, needs and priorities, or 'driving the health of the community'. Communities also influenced the establishment of culturally- based programs, helped in advising on cultural aspects affecting health care, and were advocates in issues affecting health care. Sometimes it was whole of community participation, but often it was the influence of an Indigenous staff or board member who was also a community member who bridged health systems and community views, values, and beliefs. The extensive use of representative quotations here is to enable Indigenous understandings of the meaning and process of participation to shine through. The narratives are the foundation of conceptual development.

Identifying health care issues needs and priorities*.*

In each community, there were mechanisms for community members and service staff to share ideas, information, and make joint decisions about quality improvement, although there were different methods employed at each service. For example, in Service 2 there were open 'whole of community' meetings where community members could sit down together with health service staff and discuss any aspect of health. This included health service staff acting as advocates to improve things such as housing and patient transport. This discussion, at the grass roots level, was preferred to having a formal complaint mechanism that involved filling out a form. "*At a community level we're having an open community meeting – we're out in front of the community. We open it up. They've got any concerns or issues with health service delivery, whether it's a service delivery issue,… what we've been doing right and what are our challenges and if we've got challenges then* [they] *certainly let us know* (Male Indigenous manager Service 2)

whether it's an external health service issueb...we play a big role in advocating on the community's behalf …so you tell us from a grass roots perspective,. At that grass roots level, it's about sitting down and talking ...not having a complaint mechanism – 'fill out this form', 'put your complaint in' and people want to have that discussion – have that talk.

In two services there were regular discussions between groups of community people and health service staff about changes in health service delivery they would like. At Service 6 there was a "*whole morning talking with the women. It's a two-way conversation around what we already provide and what women really feel they need and the issues around birthing in a different place when they have to leave town.* (Female non-Indigenous clinician Service 6)

There is a So we've had the discussions before and we actually produced a document a few years ago which was women's views around leaving their communities for birthing. (Female

At Service 3 community consultation about how patients' wanted the doctors clinics to work resulted in the decision to have an appointment system. *"So we have put in one for when the doctors come on the understanding that people who don't make an appointment will be seen in between the appointment times.* (Female non-Indigenous clinician service 3)

Different approaches were taken to community input into health planning and decision-making but there were opportunities for community members to influence the delivery of services in these continuously improving services.

Beyond participation; driving the health of the community

In one community, there was strong and powerful community participation in whole of community health planning, action, and advocacy leading to quality improvement in health care. The extent and strength of this community participation, in partnership with health professionals, led to interviewees in Service 1 calling this 'driving the health of the community'.

…there's also quite strong people in the community that drive the health of the community to improve the community health. They do have a lot of say from what I understand. People are taking control of their own health and we've got a Health Committee here. That's been set up to look after the health in general of the community - things that work hand-in-hand with the clinical side. (Female Indigenous community member service 1)

The Health Committee had representation from the local Council, Elders and different health units and government agencies with the idea being that there was sharing of ideas, planning and action. One clinician/manager at Service 1 saw this joint planning as "*the beginning of the direction of our future health. So it's good you try to get them* [the community] *to drive it and* *for them to be empowered and they make the decisions".* (Female non-Indigenous manager service 1)

We've got the manager from the Council and then we have Elders represented on the committee and we've got representatives from the different health units in the community and representatives from [agency names] *involved. So the idea for them is to feed in and we can take ideas from there. We'd all agree that we'll be coordinating with each other and that was*

A key role of the community group was advocacy about the issues that the community felt strongly about. The chairperson thought that group advocacy, rather than through the voice of one person, was more effective.

'Driving the health of the community' was a partnership between health care providers, service users, and community members to plan and implement health care improvements. This included group advocacy which the chairperson of the Health Committee thought was more effective than the voice of one person. "*You know it's not so good if you have one stakeholder department doing their thing …One person signing a paper saying a request or a complaint or whatever is not as effective as if it's a group that represents the community".* (Male Indigenous community member service 1)

Community influence in implementing new models of care

Quality improvement is all the more achievable when models of PHC are available that are responsive to the cultural contexts and culturally embedded. An example of community influence to bring about change in the way PHC services were delivered was from the community in which Service 6 was based. The Aboriginal health service senior manager was highly motivated to introduce a new model for care for chronic and other illness based around the family rather than the individual patient. *I* [senior health manager] *said, 'you know this is chronic disease data to you but to me it's my families ... I know that right across this country* *doctors see individuals, even Aboriginal people so I developed this Family Approach with a position for a Community G.P* [general practitioner] *to work with families in a holistic way... And the whole thing of working with families is that you're empowering families and if you're going to 'close the gap'*[1] *in all areas. I think for too long our mob have been caught up in the mainstream way of working that's really disempowering and it's taken away that responsibility.* (Female Indigenous manager service 6)

What I also wanted to show was that when you're working with Aboriginal families, you have to develop a relationship and trust when you're delivering these services I think we have to get back to the basics of empowering communities and getting them involved

Having Indigenous people in positions of power in these PHC services or in the community and passionate about improving the health of their community was fundamental. Almost always, Indigenous staff had to struggle to introduce more appropriate and culturally based models for healthcare as one manager relates. *" And it was very different approach because the Health Service weren't used to this. It took a lot of hard talking to say well look, this is how things have to be.*

Another Indigenous manager relates how difficult it was to make changes to achieve culturally safe programs. *…it* [sighs] *it wasn't easy. We had to butt heads with people and challenge – even funding bodies* [who said]*, 'when you gonna sign your contract?'*[We said] *It doesn't fit what we believe should be done. We had to stand up to a lot and it was good to have that acknowledged* [one of the continuously high improving services] *It sort of reaffirms everything we've been pushing really hard.* (Male Indigenous manager service 6). It is highly unlikely that change would have occurred without Indigenous staff's struggle.

Advising on cultural beliefs, value and practices affecting health care

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[1] 'Closing the gap' is a national policy to address the disparity in life expectancy between Indigenous and non-Indigenous Australians

From the perspective of both Indigenous and non-Indigenous health professionals gaining knowledge about the ways in which historical, political, and cultural events affect Indigenous health and health care is vital. There were many examples from Indigenous participants of how they interpreted beliefs, values, and practices, significantly affecting health care, to non-Indigenous staff.

...and I think the A.M.S. [Aboriginal Medical Service] *being able to advocate strongly and we always have and we always will, on behalf of cultural matters and also being there as a support to community health and the hospital and government services that come in. When they need advice too, because they're all new here and sometimes they're confronted with situations with their clients or families. They don't know what to do so- and I've always said, 'my door is always open. We're here! Use us!* (Male Indigenous manager service 6)

Cultural matters that impact on health care require Indigenous staff to carefully interpret the situation to the non-Indigenous staff. "*The new staff at the hospital were shaken* [by a cultural practice] *and I had the staff in my office and she was shaking and didn't understand it. So I was able to then give the context*. (Female Indigenous manager service 6)

Overarching characteristics of community participation

It is clear from all of these narratives that Indigenous people's lives were embedded in their culture, as was their participation in their health service. We commenced our interviews broadly asking health system personnel about how CQI was operationalised at the service. It was striking that several Indigenous and one non-Indigenous participant in three services spoke firstly about the importance of culture and how it affected all aspects of life including health service provision. A Torres Strait Islander community representative tells us about the rule of culture. "*The rule of culture is vitally important coz it's everything I guess ...culture is pretty much our belief. Bottom line. What we believe and you can't negate culture from anything that happens coz it is the way we believe and the important thing is people understand those beliefs and how do we best balance those things in a way that will be* *productive going forward in what we're meant to do?"* (Male Indigenous community representative service 1)

A non-Indigenous manager at the same service gave her perspective of the importance of culture and how it is embedded in all aspects of health service delivery including CQI. *"It is just sort of getting to know - understand the culture. The whole history basically, which is really very interesting. These people talk about their past, their families and that system functions through the little ones that got names of their grandparents and aunty and uncles and so they're all joined together and so that's sort of a respect and that's how you function. It is a general respect and general trust and certainly um it's just fitting in with everybody".* (Female non-Indigenous manager health service 1)

In one ACCHS the focus on culture and operating appropriately within this was fundamental. "*Our culture is our foundation here. If you go out of your bounds you know - morally inside you don't feel right.* (Male Indigenous manager service 2)

In order for the health services to be able to provide quality care it was thought essential by Indigenous and non-Indigenous staff alike that culture was respected and understood. At each of the services, variously termed formal 'cultural awareness', 'cultural safety', or 'cultural security' training was in place orienting staff to important cultural aspects that were seen as fundamental to quality health care. "*A lot of the relief nurses they come in, and the Elders and I have a sit down with them first and I will talk to them about the cultural awareness here and you can't just go and do stuff around …there's a cultural protocol. You gotta ask first before you go. I try and tell them to get them to know the patient through me first.* (Male Aboriginal Health Practitioner service 5)

An Indigenous senior manager spoke about not just using the terms such as 'cultural awareness' but engaging in genuine learning and sharing through relationships as well as formal training. He was aware that at times the words like 'cultural awareness' were used without a genuine commitment to becoming culturally aware. *People use the word cultural* *appropriateness like a hooker! They're not really understanding what it means. I feel very strongly about that*. (Male Indigenous manager service 6)

Two-way conversations; 'a level of half understanding between us' (Female non-Indigenous manager service 1)

The overarching result of community participation was the opportunity for people from very different backgrounds and experiences to come together and share their perspectives. Sharing of perspectives was an important overall process related to implementing CQI and other health improvement strategies. Both Indigenous and non-Indigenous staff and community members described this sharing in a variety of ways.

…*Their* [Indigenous people's] *traditional ways are different and before they* [health professionals] *go and talk to people, they really need to sit back and understand their ways first. So when they're out there to do health education and stuff like that, they need to know the audience. And how you're going to approach them. You can't just come and say your sugar level's bad, your diabetes is bad, you need to do this, you need to do that. That's where you need to build a relationship in the community. You need to understand their lifestyles and history or otherwise how can you work together in the health system. It works both ways. (*Female Indigenous health service user service 1)

Aboriginal Health Practitioners play a vital role in the PHC workforce, providing clinical and primary care for individuals, families and community groups. They are also key in sharing cultural knowledge. *Well I think having the Aboriginal health workers on board - it's that two-way learning and I'm a believer of two-way learning and that is between health workers and the doctors.* (Female Indigenous manager service 5)

A non-Indigenous staff member was able to describe the complexity around the idea of two-way learning. *I always like to use the word "tuning in" – tuning in to people. Different frequencies. Listen to them. Understanding them and I can utilise my knowledge with their* *knowledge to bring a level of half understanding between* [us]. (Female non-Indigenous clinician, Site 1)

The melding of technical skills with local knowledge is clearly explained by an Indigenous manager at service 6. *But sometimes it takes time for people to get to know us, not the other way around. They're the new ones here – they gotta remember they're the strangers here. They come with all these skills and knowledge – give them every tick for that. But still they don't have local knowledge and an idea of who the people are in the communities that they're servicing - and they need to.* (Male Indigenous manager, Site 6)

Discussion

An understanding of community participation in these health services involves a genuine acknowledgement of the importance of culture to Aboriginal and Torres Strait Islander people and how it underpins all aspects of life. While the manifestations of community participation such as devising new and more appropriate health programs, participation in community-based health committees, and being custodians of new ways of working in partnership are important, it is the processes underpinning them that are crucial. The point that Indigenous participants make continually about the importance of culture – 'that culture is our foundation' (male Indigenous manager service 2) – must be understood as vital to the interactive decision-making or self-mobilisation stages of community participation (Snijder, et al. 2015)

Parts of the health system, especially government health authorities, generally understand community participation from an instrumental perspective, where participation might be seen as culturally neutral (Morgan 2001). It is assumed that community participation involves processes initiated by the health system and applied similarly in any cultural setting, despite historical writing about community participation having stressed the significance of local and cultural variability in determining outcomes (Morgan 2001; Rifkin 1996). Australian Indigenous authors, writing about Indigenous health, make explicit that a process, such as community participation in health, is never culturally or politically neutral (Bond, Foley & Askew, 2016; Champion et al. 2008; Fredericks 2010).

Building concepts about the link between Indigenous community participation and CQI involves incorporating the way in which culture permeates, underpins, infuses, and surrounds those activities that might be seen as straightforward tasks. To complement and strengthen Ithe participant's insights reported above we add a narrative from Nalita Turner who speaks from her perspective as an Aboriginal woman, anthropologist, and community member who for years has been active in trying to improve Aboriginal health and well-being.

"I am an Anmatyerre/ Jaru woman from Central Australia and I share my background and understandings. My obligation as an Aboriginal anthropologist and a researcher is to support, advance, and enhance Aboriginal Australia in whatever capacity I can. Working out of "country" is exciting and demanding. It is my responsibility to know and understand that every Aboriginal community is unique, different, and cultural traditions have existed and been respected for thousands of years. The terminology that we use when we approach Aboriginal communities, their health services, and their community people, the 'user', is a key to shared learning. Shared learning involves respect; respect the past and present aspects of Aboriginal Australians. The language that is used and what tone it portrays when speaking to Aboriginal people is important as are personal presentations such as dress, for both genders. Facial expressions are very important. Aboriginal people are very visual, so we see and hear and this is our first response. The concept of community participation is not an Aboriginal term that I would use in community. I would use 'two-way sharing' which to me means finding a space where we can talk, sharing our different views, and listening to each other. This is a safe space where we can trust each other to say who we are and what we believe and open up to each other."

There are intertwined elements in this Indigenous concept of two-way sharing. Trusting relationships based in respect are central (Kelly 2006; Coffin 2007). Indigenous interviewees variously referred to the trusting relationships they had with non-Indigenous health personnel as ‘[health professional] being one of the community’ or ‘not being frightened to talk to them [health professionals]’, or ‘having them know our situation’. Trusting relationships between community members and health professionals extended outside the boundaries of the health system and sometimes the professional relationship was enhanced by these friendships.

Intertwined with trusting relationships is the element of a metaphorically ‘safe place’ for community participation to occur. Fredericks (2010) writes compellingly of the many inscribed cultural meanings associated with healthcare services in rural Australia. The meanings for Indigenous Australians might be of a culturally safe, inclusive, and friendly service, or it might be seen as exclusive and demanding a great deal of angst and energy for them to approach (Fredericks 2010). In our study, service personnel tried to make their health ‘places’ safe for community participation using a variety of means; the strongest was to hold whole-of-community meetings in the community. In several communities the health centre was seen as part of the community and therefore accessible and safe.

Finally, there is the element of two-way learning that has been continually promoted by Australian Indigenous scholars often from the perspective of arguing for recognition of Indigenous capacity (Geia, Hayes, & Usher, 2011; Sherwood, et al., 2015). In our study, the two-way learning referred to the challenge of sharing values, perspectives, and understandings of health and CQI against the backdrop of different cultures and world-views. One interviewee made the complexity of this process clear to us when she said to ‘come to a level of half understanding between us’. Many interviewees felt that two-way learning was occurring through sitting down together and incorporating community and cultural perspectives into healthcare.

Sherwood (2013) argues that two-way learning is vital in order to increase non-Indigenous Australians understanding of the historical and political events contributing to social health determinants that undermine Indigenous health and well-being. Creating this kind of partnership in which conceptual and social learning (Wise et al. 2013) flourishes will enable non-Indigenous health professionals to listen and understand their Indigenous colleagues and

patients. If partnerships persist over time Indigenous people's values and societal goals will be expressed firmly within health care programs enabling improved health outcomes (Houston 2004;
Sherwood & Geia 2014). The importance of Indigenous health professionals, in particular Indigenous Health Workers, playing a vital boundary-crossing role between their communities and their health service is central to these processes (Geia, et al., 2011).

A limitation of this study was that it involved just six PHC services, selected on the basis of high-improvement in response to CQI. However, the diversity in size, remoteness, governance, and jurisdiction of these services suggests that the findings are likely to be transferable to other similar services, at least across northern Australia. Given the remote location of the services and managers and clinicians based in disparate locations not all key personnel were interviewed. A further challenge was in understanding the different world views of Indigenous service users and community members and aligning them with traditional concepts of community participation. In doing this we found a strength was the team-based approach of Aboriginal and non-Indigenous researchers working together.

Conclusion

There are two ways in which conceptual development about community participation might strengthen Indigenous health care provision. First, the recognition of the elements involved in two-way sharing, trusting relationships, safe spaces, and learning from each other, might assist in forming genuine partnerships between non-Indigenous and Indigenous health professionals and their patients, so that community participation achieves the intended objectives. Second, there might be a more explicit link made between the cultural, historical, and political factors operating in the context in which Indigenous people live and the effect of this on CQI and other health system processes. Identifying contextual factors affecting CQI has been challenging. If community members participate openly from their community, cultural, and historical foundation then all health system personnel, supported by Aboriginal Health Workers are able to learn first-hand about factors affecting the community's health, including important social determinants, and make appropriate modifications to programs or even enable new ones. Ideally programs and services are embedded in Aboriginal or Torres Strait Islander cultures.

Our study uncovered working examples of two-way sharing in Indigenous PHC health activities. These examples build upon other excellent health examples of Indigenous community participation that have been recorded (Bond, et al. 2016; McCalman et al. 2015; Sherwood et al. 2015; Singer, Bennett-Levy, & Routumah, 2015). However, there are many examples that remain unrecorded, with the result that the empirical data needed to advance conceptual development and practical guidelines for effective community participation in Indigenous settings is incomplete. Indigenous scholars, communities, and community controlled health organisations, are beginning to take up this challenge promoting Indigenous understandings of what it takes to improve their communities' health.

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Declaration of conflicts of interests

The authors declare that there is no conflict of interest.

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Table 1 Case study sites

Site	State	Governace	Rurality	Population	% identify as Indigenous
1	QLD	Government	Remote	<=500	99
2	NT	ACCHS	Remote	501-999	93
3	QLD	Government	Remote	<=500	92
4	NT	Government	Regional	501-999	23
5	NT	ACCHS	Regional	>=1000	100
6	WA	Government/ACCHS partnership	Remote	>=1000	67

Note: QLD = Queensland, WA = Western Australia, NT = Northern Territory

Table 2 Interview participants

Service 1 **Category**	**Indigenous**	**Non-Indigenous**	**Total**
Clinical/ management personnel	0	4	4
Service users	10	0	10
Total			14

Service 2 **Category**	**Indigenous**	**Non-Indigenous**	**Total**
Clinical/ management personnel	3	11	14
Service users	10	2	12
Total			26

Service 3 **Category**	**Indigenous**	**Non-Indigenous**	**Total**
Clinical/ management personnel	19	39	58
Service users	51	18	69
Total			134

Service 4 **Category**	**Indigenous**	**Non-Indigenous**	**Total**
Clinical/ management personnel	19	39	58
Service users	51	18	69
			134

Service 5 **Category**	**Indigenous**	**Non-Indigenous**	**Total**
Clinical/ management personnel	19	39	58
Jurisdictional management non-site personnel	0	7	7
Service users	51	18	69
			134

Service 6 **Category**	**Indigenous**	**Non-Indigenous**	**Total**
Clinical/ management personnel	19	39	58
Jurisdictional management non-site personnel	0	7	7

Service users	51	18	69
			134