Improving the quality of primary health care is essential for Closing the Gap in health and wellbeing disparities between Aboriginal and Torres Strait Islander people and other Australians.

The Centre for Research Excellence in Integrated Quality Improvement (CRE-IQI) brought together service providers, communities, policy makers and researchers to work on strengthening the primary health care system through quality improvement.

This is a final report of the CRE-IQI research findings and activities, with messages for action to improve primary health care delivery.
About the CRE-IQI

Aboriginal and Torres Strait Islander people’s health outcomes, life expectancy and access to health care should be equal to that experienced by other Australians. To address both the current inequalities and improve primary health care for Aboriginal and Torres Strait Islander people and communities, we need a whole-of-system view that uses evidence, innovative thinking and Indigenous-led, collaborative, strengths-based approaches.

The vision of the Centre for Research Excellence in Integrated Quality Improvement in Indigenous Primary Health Care (CRE-IQI) is to improve Aboriginal and Torres Strait Islander health outcomes by accelerating and strengthening large-scale quality improvement efforts. Continuous quality improvement (CQI) is a systematic way of using data to guide ongoing improvements to the quality and consistency of primary health care (PHC) as well as to its organisation, structure and/or design. Recognising the need to scale-up CQI efforts in Aboriginal and Torres Strait Islander health, Australia’s National Health and Medical Research Council funded the CRE-IQI from 2015 to 2019 (#1078927). The CRE-IQI brought together researchers, service providers and policy makers – from Aboriginal Community Controlled Health Organisations, government-managed health centres, research institutions, government health departments and key regional support organisations such as health councils – to work on ways to strengthen system-wide quality improvement.

Building on more than two decades of participatory CQI research and development involving Indigenous communities, health services and researchers across Australia, the CRE-IQI research aimed:

- To refine and build new audit processes and tools
- To improve data reporting systems at all levels of primary health care
- To increase the use of quality improvement data in clinical governance, management and practice
- To strengthen quality improvement capacity in the Aboriginal and Torres Strait Islander health workforce
- To monitor and evaluate the impact of the innovation platform.

Three cross-cutting work programs aimed to build collaboration, strengthen research capacity and translate research outcomes into health policy and practice. For details see https://ucrh.edu.au/cre-iqi/.

Note on terminology

In this report, we primarily use the term ‘Indigenous’ to refer to Aboriginal and Torres Strait Islander peoples and groups whose ancestors pre-date colonisation and who identify as such; ‘Aboriginal and/or Torres Strait Islander’ is also used where appropriate.

Abbreviations

ABCD  Audit and Best Practice for Chronic Disease
ARF/RHD  acute rheumatic fever/rheumatic heart disease
CQI  continuous quality improvement
CRE-IQI  Centre for Research Excellence in Integrated Quality Improvement
PHC  primary health care
How CRE-IQI Members Have Worked Together – An 'Innovation Platform'

The CRE-IQI used an 'Innovation Platform' concept (1). This is an open network of members from diverse roles and organisations who come together to work on shared goals, find solutions to common problems, learn from each other and take collective action.

Figure 1 shows the Key Functions of the CRE-IQI listed in the eight circles, with our Guiding Principles encircling them. These were collaboratively developed using Aboriginal and Torres Strait Islander leadership and direction of research as a key principle. At the centre is our overarching aim of ‘All teach, all learn’, which reflects the value placed on mutual learning between everyone involved in the CRE-IQI’s research.

Figure 1: Elements of the CRE-IQI Innovation Platform
Findings and Insights from the CRE-IQI

The diversity of the CRE-IQI’s membership and its collaborative way of working have ensured that our research is grounded in the real world. We used a collaborative process that drew on CRE-IQI publications and the collective knowledge and experience of our members to identify the most important findings and insights from our research program.

CQI has been widely accepted and applied in Australian Aboriginal and Torres Strait Islander health services and in PHC settings, with some resulting improvements in clinical care, service systems and the social determinants of health.

Our research shows that sustained use of CQI can improve the delivery of evidence based PHC (2–13). Participatory CQI approaches can be adapted for identifying and addressing improvement priorities across a range of program settings and at different system levels (5, 14–20).

The CRE-IQI identified the following factors as enabling teams to engage effectively in CQI at different system levels.

At the policy level they include:

+ Backing of higher level policy, CQI infrastructure and regional-level support (9, 14, 21, 22).
+ Whole-of-organisation approaches to CQI supported by leadership at all levels and funding for CQI processes (21, 93, 23).

At the health service level they include:

+ A stable and well-prepared workforce, with teams that have a mix of skills, and clear roles and responsibilities (10, 14, 22–25, 93).
+ Stable CQI systems and supports, teamwork and collaboration between staff (14, 23, 24).
+ Strong community engagement, and linkages and partnerships with external organisations (14, 15, 24).
+ Participatory CQI approaches that are contextually relevant and responsive to local needs (10, 15, 17, 24, 26).
+ Adapting CQI approaches to suit program or service settings (5, 14–20).
+ Skilled facilitation in supporting CQI (20–23, 27–30).

Aboriginal and Torres Strait Islander leadership and participation in PHC services and research improves the quality of care delivered.

+ Aboriginal and Torres Strait Islander staff are crucial to improving the delivery of evidence-based care (11, 28, 31), including access to culturally safe PHC and continuity of care (15, 31, 32).
+ Local-level leadership and decision-making for health and wellbeing services can improve the implementation of CQI and service delivery (15, 33, 34).
+ PHC services with leadership by, and engagement with, Aboriginal and Torres Strait Islander people and communities consistently achieved high improvement in the delivery of evidence-based care (14, 15). In these high-improving services, there was a mix of Indigenous and non-Indigenous staff with deep knowledge and understanding about the communities in which they were working and the most appropriate ways to deliver PHC (14, 15).
+ Our work has reinforced the need for more Aboriginal and Torres Strait Islander control, ownership and leadership of CQI research. This can be achieved through formalised processes that embed principles of practice into ongoing research (35), and funding that is controlled and led by Aboriginal and Torres Strait Islander people (17, 94).
+ The strengthening of research capacity needs to be embedded in health research activities and programs (35, 95).

The ABCD program built CQI capacity across 270 health centres and involved more than 1200 health providers. Every dollar spent created between $1.61 and $4.80 in value, with the economic benefit coming from leveraged research and scholarship funding, new CQI positions and savings in the ‘downstream’ costs of care.

(Unpublished impact assessment findings)
Clinical and non-clinical health outcomes can be improved by using evidence-based CQI tools and processes.

- ABCD CQI tools and processes are available to health services, and have proved reliable and valid for monitoring and improving the key functions of PHC (27, 29, 96). Use of CQI tools and approaches has proved feasible for improving the delivery of chronic illness care (6, 9, 36, 97), child health (3, 7, 98), maternal health (2, 4, 99), preventive health (44, 100), mental health and wellbeing (8, 101), sexual health (22, 38), and acute rheumatic fever and rheumatic heart disease (ARF/RHD) care (10, 39, 102).

- CQI tools developed through the ABCD project are adaptable to context, including the health promotion and systems assessment tools (27, 29), but there is limited use of some important CQI tools by PHC services (36, 101).

- CQI can strengthen systems to support comprehensive PHC (40) that attends to the social determinants of health (40, 41). CRE-IQI research shows that a CQI approach is feasible and promising for health promotion (5), wellbeing empowerment programs (17), strengthening food security systems (16), management development (12), child protection processes (43), and in school settings (42).

- Applying CQI tools and processes supports team building and learning (5, 30). It also has benefits for planning, decision-making and capacity building at the health centre level (24).

- Systems and infrastructure are needed to support staff training in CQI, including in the use of information systems and clinical audits (44, 45).

Access to accurate and timely data across the scope of practice is essential for CQI in comprehensive PHC, and for informing and driving health service, intersectoral and community action.

- Clinical information systems that are fit for purpose and context can provide relevant data and support improved practice (36); there is also a link between clinical information system quality and integration, and service quality (14, 24, 36). However, many of these systems are not designed to provide data for CQI (5, 25, 44) leading to critical gaps both in client data (45, 46, 96) and health promotion activity data (5).

- Clinical audits are vital in generating data in areas not adequately covered by existing clinical information systems and for monitoring the quality of data recorded in them (14, 30).

- Regional and/or higher level standardised clinical information systems enable identification of system-wide gaps, the monitoring and evaluation of trends in best practice care, and the longer term impacts of CQI on practice and health outcomes (100, 102).

Priorities have been identified for strengthening PHC systems to achieve large-scale health improvement for Aboriginal and Torres Strait Islander people.

Many aspects of care are being done well in health services, including the measurement of weight, blood pressure and glycated haemoglobin (HbA1c), and the ordering of tests for clients with chronic illness (47, 97). The successful delivery of health assessments is associated with superior preventive care (11, 36). However, there are many other aspects of care that need to be improved. Identified priorities for improving PHC delivery are as follows.

- Increasing follow-up of abnormal clinical results in chronic illness care (25, 47, 97), child health (25, 44, 98), maternal health (99), preventive health (28, 100), mental health and wellbeing (8, 101), and ARF/RHD care (102).

- Enquiring about behavioural risks to each client’s health, and providing brief intervention as required, is a priority across the scope of clinical PHC (48, 97–102).

- Ascertaining social and emotional risk factors and, when risks are identified, providing brief intervention and support was an identified need in maternal health (4, 49, 99), preventive health (8, 28, 100) and chronic illness care (97).

- Improving documentation of the care provided (98).

- Providing better referral systems (in-service and externally) and service options, particularly locally for referred clients (8, 49).

- Addressing barriers to the delivery of quality care in the suitability and use of clinical information systems, workforce, staff skills/training, financial resources and community engagement (97–102).

CRE-IQI research shows wide variation in the delivery of care between health services and between jurisdictions, which is largely explained either by health centre factors (5–7, 37, 38, 47, 50–53) or policy-level factors (21, 22, 36, 50, 51, 53). This indicates the need to strengthen systems for delivering PHC at different levels of the health system.
Our Research Projects

6 Flagship projects

+ Engaging stakeholders in identifying priority evidence-practice gaps and strategies for improvement in primary health care (ESP project)
+ Ongoing analysis and reporting of data from the ABCD National Research Partnership
+ Quality improvement in Aboriginal primary health care: Lessons from the best to better the rest
+ CQI approaches to sustainable implementation of social and emotional wellbeing programs and services
+ Strategies for improving provision of maternal health care for Aboriginal and Torres Strait Islander women
+ Monitoring and evaluation of the CRE-IQI as an innovation platform

12 Aligned priority projects

+ Quality improvement in Indigenous PHC – The Leveraging Effective Ambulatory Practices (LEAP) project
+ WOMen’s action for Mums and Bubs (WOMB): A pragmatic trial of participatory women’s groups to improve Indigenous maternal and child health
+ Opening doors: Evaluation of the Maari Ma Health Aboriginal Corporation’s Chronic Disease Strategy
+ Implementation of health promotion quality improvement tools and processes in the Northern Territory
+ Development of indicators and quality improvement tools for tobacco control programs in Indigenous communities
+ Evaluating the CQI approach for program impact and diversification of the Remote Management Program: A feasibility study
+ Aremelle Arratayenye-ileme – Doing it right: Research knowledge generation and translation in Central Australia
+ B.strong: Queensland Health Aboriginal and Torres Strait Islander brief intervention training program
+ Assessing and guiding system improvement for delivery of preventive health care for Aboriginal and Torres Strait Islander Australians: Validating a data collection and measurement tool
+ VOICE: Validating Outcomes by Incorporating Customer Evaluation
+ Health from the grassroots: Consulting community about health and research priorities
+ System-level integration to promote the mental health of Indigenous children: A community-driven mixed methods approach

Evaluation of the CRE-IQI

The CRE-IQI implemented a developmental evaluation, a network evaluation and an impact assessment. Using developmental evaluation, we have been able to draw on feedback in different ways across all levels of the CRE-IQI to inform our operations, work programs and future direction. We have achieved this through continuous reflection, learning and adaptation. Based on feedback from members, a key activity was to increase the leadership and participation of Indigenous people in all aspects of our work.

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The network evaluation was applied across the lifecycle of the CRE-IQI to identify strategies for improvement and to evaluate its operation using network methods. The CRE-IQI built on long-standing partnerships and helped members to build new relationships – a marker of the success of the innovation platform – leading them to rate ‘Facilitating collaboration’ as the CRE-IQI’s most strongly recognised achievement. Members strongly agreed that the CRE-IQI had met its goals, and assisted them in their work and/or in their health service (103).

The impact assessment used the Framework to Assess the Impact of Translational Health Research to evaluate three of our ‘flagship’ projects to understand their impact on knowledge, policy, the health system, health care, health outcomes and the economy. The most significant combined impacts were in capacity building of health services and in policy.

The innovation platform approach, based on a partnership-learning model (54), brought together a diverse group of people (1, 102, 55) to implement, reflect on, evaluate and disseminate CQI research (95). It inspired collaboration with a wide range of stakeholders and quality improvement approaches across multiple levels of the health system (1, 94). Aboriginal and Torres Strait Islander leadership, collective priority setting and problem solving supported learning and change across the CRE-IQI (35).

The ‘Lessons from the best to better the rest’ project used the findings from consistently high-improving services to leverage $1.1 million to strengthen striving services and develop a CQI toolkit.

(Unpublished impact assessment findings)

For project descriptions and aims see https://ucrh.edu.au/cre-iqi/.
Messages for Action, Impact and Research

For health services

• Invest in PHC workforce recruitment and retention strategies that address high staff turnover.
• Increase and support the Aboriginal and Torres Strait Islander health workforce at all levels and establish professional pathways and opportunities for training and two-way mentoring.
• Improve identification of Aboriginal and/or Torres Strait Islander clients in patient records in PHC settings.
• Modify and integrate clinical information systems, as required, to generate data for improving care coordination and delivery.
• Advocate for training and development in CQI facilitation skills.
• Allocate time and resources for staff at all levels and roles to participate in CQI training and activities.
• Facilitate Aboriginal and Torres Strait Islander community engagement in CQI, and in planning and evaluating health and wellbeing programs.
• Focus on preventive health care and health promotion using culturally appropriate and strengths-based approaches.
• Continue to collaborate in CQI research.

For policy, government and support organisations

• Resource jurisdiction- and regional-level service providers to implement the 'National Framework for CQI in Primary Health Care for Aboriginal and Torres Strait Islander People 2018–2023'.
• Strengthen the use of information systems within PHC to record brief interventions for lifestyle risk factors, enable follow-up of abnormal results, and further incentivise through the Medicare Benefits Schedule.
• Encourage the use of CQI to strengthen systems for addressing the social determinants of health.
• Work with communities to incorporate Indigenous perspectives on care quality into the measures of quality used in CQI.
• Allocate funding for dedicated CQI roles/functions and processes and for staff at all levels and roles to participate in CQI training and activities.
• Support the use of tools and processes that enable services to identify and address local priorities for improvement, in addition to meeting their reporting requirements.
• Invest in data literacy and data analysis skills at all levels of the health system to build understanding and capacity in generating and using data to inform decision-making.
• Further develop systems to improve data quality at PHC level, to aggregate data at different system levels and to monitor trends in best practice care, CQI impact and whole-of-system responses.
• Continue to invest and collaborate in CQI research in Indigenous PHC.

For researchers and service–policy–research collaborations

• Encourage and support diverse collaboration in CQI research.
• Empower community members and service providers to co-lead projects and collaborate in research teams, including formal opportunities to learn and apply research skills.
• Conduct implementation studies to address the variation across services in delivery of care.
• Undertake more research to understand why and how CQI works in different contexts, and to advance facilitation techniques.
• Develop CQI tools to monitor client experiences of PHC.
• Further refine the ABCD (Audit and Best Practice for Chronic Disease) tools to meet the ongoing CQI implementation needs of PHC services.
• Advance the application of CQI for health system strengthening and for engaging intersectoral action to improve health and wellbeing.
• Conduct economic studies to understand more fully the return on investment in CQI.
• Establish clear objective measures to monitor the impact of CQI on the broader health system.
**Engagement and Impact**

**Research translation**
- **92** peer-reviewed publications
- **450+** citations
- **184,800+** downloads
- **26** newsletters
- **70** average of 70 individual opens per newsletter
- **7** policy/parliamentary submissions
- **2600** responses received through an interactive data dissemination process to identify priority gaps, barriers, enablers and strategies to improve care
- **27** research and technical reports
- **81** conference presentations
- **26** newsletters
- **70** average of 70 individual opens per newsletter
- **7** policy/parliamentary submissions
- **2600** responses received through an interactive data dissemination process to identify priority gaps, barriers, enablers and strategies to improve care
- **27** research and technical reports
- **81** conference presentations

**Collaboration**
- **85** different organisations had contributing authors on our peer-reviewed publications
- **10** biannual meetings to bring together collaborators
  - 4 locations: Brisbane, Alice Springs, Darwin and Cairns
  - 120 individuals attended at least one biannual meeting
- **$31,998,410** leveraged in collaborative research grants
- **18** affiliated projects
  - investigators from 27 different organisations on CRE-IQI projects
- Strong connections between members supported the sharing of information across the network
- **53%** of CRE-IQI members shared information, and
- **43%** collaborated with people they didn’t know before their CRE-IQI involvement
- **47** different lead authors from 22 different organisations
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- **47** different lead authors from 22 different organisations

Network evaluation found that collaboration and networking opportunities were highly valued by members
Publications had a student/program officer as lead author

Funded position to support research capacity strengthening
- established lead group
- developed ‘All teach, all learn’ framework

Masterclasses enabled researchers and service providers to access professional development on topics identified by CRE-IQI members

Individuals attended at least one masterclass

Leveraged in scholarship and fellowship funding

Research capacity strengthening

24 students affiliated (PhD, Masters, undergraduate placements)

31 research capacity strengthening seminars held

15 publications had a student/program officer as lead author

16 masterclasses enabled researchers and service providers to access professional development on topics identified by CRE-IQI members

166 individuals attended at least one masterclass

$2,600,920 leveraged in scholarship and fellowship funding

Indigenous leadership and participation

64 of 73 articles about research conducted with Aboriginal and Torres Strait Islander communities or using ABCD CQI data had at least one Indigenous author

88% of presentations had at least one Indigenous author

67% of individual attendees at biannual meetings were Indigenous and/or representing an Indigenous organisation

46% of individual attendees at masterclasses were Indigenous and/or representing an Indigenous organisation

28% ↑ 44% Participation by Indigenous people and organisations increased from 28% in the first biannual meeting to 44% in the final 2019 meeting

Established co-leadership arrangements between Indigenous and non-Indigenous researchers
CRE-IQI Research: A Visual Bibliography of our Publications

Developed by K Conte, A Laycock with members of the CRE-IQI. Illustration by Studio Elevenses | December 2019

*Each number corresponds and links to an article in the List of References in this report (see pp. 12–14).
The CRE-IQ has produced 92 peer-reviewed articles and books, which we have numbered* and organised into interrelated themes that reflect how our research explored and extended the use of CQI in Aboriginal and Torres Strait Islander primary health care (PHC). Together these publications show the research journey of the CRE-IQI, and the contributions of the many members who are part of this dynamic system.

**How can CQI improve PHC?**

Sustained use of CQI is associated with improved delivery of best-practice care

- 2
- 3
- 4
- 5
- 6
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- 9
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- 12
- 13

... but not always...

- 38
- 77

Plateauing effect

Other effects

- 60
- 70
- 75

Indigenous leadership and stable workforce

Policy and regional-level support

Information systems

CQI facilitation

What supports CQI?

Research protocols

- 19
- 42
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- 68
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Research impact and translation

Tools for thinking, CQI and action

- Conceptual models and frameworks
- Developmental evaluation
- Systems assessment and planning
- Audit and feedback
- Research impact and translation

How can we better learn about improvement?

Literature reviews

Study

Engagement and impact

Tools for thinking, CQI and action

E-books
Articles


14. Larksin S, Carlisle K, Turner N, et al. 2019, ‘At the grass roots level it’s about sitting down and talking’: Exploring quality improvement through case studies with high-improving Aboriginal and Torres Strait Islander primary healthcare services, BMJ Open, 9(5).


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NB: References 56–92 are cited in the Visual Bibliography only.
Improving the Quality of Primary Health Care for Aboriginal and Torres Strait Islander Australians

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Reports

93 Newham J & Cunningham F 2015, Continuous Quality Improvement Success Stories: Identifying Effective Strategies for CQI in Aboriginal and Torres Strait Islander Primary Health Care – Study Report, ABCD National Research Partnership, Menzies School of Health Research, Brisbane.


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For other CRE-IQi publications see https://ucrh.edu.au/cre-iqi/.
Future Directions

Work carried out by the CRE-IQI has been crucial in securing funding for the Centre of Research Excellence in Strengthening Systems for Indigenous Health Care Equity (CRE-STRIDE) 2020–2024 (NHMRC #1170882).

CRE-STRIDE has exceptional Indigenous leadership and collaborative strengths. Service providers, policy makers and researchers will come together in a research program that aims to improve Aboriginal and Torres Strait Islander health by embedding CQI knowledge into practice supported by policy, and by expanding the use of CQI to address the social and cultural determinants of health.

The program will be built on shared principles that support Indigenous leadership and strengthen Indigenous research capacity. Using Indigenous methodologies, participatory action research, and systems thinking approaches, the research will build new knowledge for:

- increasing community engagement in quality improvement processes
- strengthening health system capacity for quality improvement
- applying quality improvement approaches to social and emotional wellbeing
- quality improvement in health promotion and prevention.

For more information on CRE-STRIDE: https://ucrh.edu.au/cre-stride/
Acknowledgments

In the spirit of respect, the CRE-IQI acknowledges the people and the Elders of the Aboriginal and Torres Strait Islander Nations who are the traditional custodians of the land and waters of Australia.

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+ Aboriginal Medical Services Alliance Northern Territory
+ South Australia Health and Medical Research Council
+ Apunipima Cape York Health Council
+ Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care (Inala Indigenous Health Service)
+ National Aboriginal Community Controlled Health Organisation.

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