

UNSW research centre for
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Occasional Paper I
What the chicken money bought:
Researching with our local Aboriginal community
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The Gudaga project is a longitudinal birth cohort study describing the health, development and health services use of over 150 Aboriginal children and their mothers living in south west Sydney (Australia).



The project's logo was designed by Tracey Skinner, a young Gumbaiyngar Yaegal mother living, at the time, in our local Aboriginal community. The logo is rich in maternal-child symbolism:

- the four squares are the four services connected to the project;
- the four heavy wavy lines are the pathways that lead the women into the project;
- the outer circle is the hospital
- the wavy line within the circle is the emotional journey of having a baby;
- the dots are the 12 months the babies will be involved in the project;
- the inner circle is the womb and the kidney shape is the foetus;
- the circle's purple colour was chosen to symbolize women.

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It isn't often public health research within a tertiary, academic setting can profess a direct link with the sale of frozen chickens but such is the "claim to fame" of the Gudaga project. It is a long story spanning ten years but one which has led to the establishment of an Aboriginal home visiting team in the Campbelltown area (a large satellite city on the urban fringe of south west Sydney) and the recruitment of a cohort of almost 160 Indigenous¹ babies whose health and access to health services is being studied in the first longitudinal study of Indigenous infants undertaken on the east coast of Australia. The study is known as the Gudaga project.

This chapter tells the Gudaga story: yarns on the verandah; early dreams and schemes; initial short term funding for home visiting and finally, a successful proposal which led to NHMRC (National Health and Medical Research Council) funding. Pivotal to the story is the way we have worked in partnership with the local Indigenous community which includes a number of groups - all of which play a very important part in the success of our research project. These stakeholder groups, and our strategies for working with each of them to ensure robust results and a successful study, are identified and described in the following discussion.

Background

The story began in 1997. At that time, researchers from the University of New South Wales (UNSW) sat with Aboriginal health workers (AHWs) on the verandah of Campbelltown's Aboriginal Community Controlled Health Service, Tharawal Aboriginal Corporation. Over many months they talked about the health problems faced by the area's Indigenous families and about ways to improve the health of Indigenous children in the area. The AHWs were concerned at the difficulties in providing access to culturally appropriate, outreach services to mothers with babies once they had left hospital. They were concerned about the impact of otitis media on the health, development and capacity to learn of local Indigenous children. The researchers and AHWs also realized that the origins of otitis media needed to be addressed early in life and not as children entered school. We all dreamed of establishing a home visiting service to provide support to Indigenous families with young children.

It is one thing to talk and dream: it is quite another to turn those dreams into reality. As we spoke to members of the Tharawal Board, local elders, mother with young children and the AHWs it was obvious that there was a great deal of concern that a home visiting program funded by the state government may not be welcome in the community. Many feared it to be a potential

vehicle for allowing welfare officers to take their children. This was a major issue with strong historical precedence. To assess the feasibility of the idea researchers from the Centre for Health Equity, Training, Research, and Evaluation (CHETRE), in collaboration with the AHWs, applied to the Ingham Foundation² for a small research grant to conduct a feasibility study of a home visiting program. This funding provided the impetus and motivation to start a pilot project – and so locally we spoke of it as "what the chicken money bought". In November 2000, a pilot Aboriginal home visiting team was established and the first home visit was made. Fears that families wouldn't welcome team members into their homes were allayed as mothers opened their doors and readily invited in team members. The Aboriginal Home Visiting Service has continued although there have been ongoing problems including organizational issues, inadequate funding, staff vacancies and difficulties in seeing all the mothers.

The Gudaga Study

A barrier to extending the Aboriginal Home Visiting Service has been the lack of epidemiological data on the health and health service needs of the area's Indigenous infants. Without this empirical evidence it has been difficult to advocate effectively for services for Indigenous families in the area.

Demographically, the area is unique in a number of ways. The Campbelltown region has, for example, one of the largest Indigenous populations in NSW comprising 3,602 people: 2.4% of the regional population of 150,000 and 5.1% of the state Indigenous population (Sydney South West Area Health Service, 2005). The area's Indigenous population has a number of defining characteristics. It is a relatively young population. In 2001, 47% of the area's Indigenous population was aged less than 15 years compared to 27.0% of the area's population (Sydney South West Area Health Service, 2005). The Indigenous population has a generally lower socioeconomic status than the non-Indigenous population. This is reflected in report of lower household incomes, higher unemployment, higher rates of incomplete schooling, and public housing tenancy than the non-Indigenous population (Sydney South West Area Health Service, 2005). For example, close to four out of ten of the region's Indigenous population live in public housing compared to one in ten of the area's general population (Sydney South West Area Health Service, 2005).

In eastern Australia, there is little information on the health status of Indigenous babies in an

¹ The word "Indigenous" has been used throughout this chapter to refer to those with either an Aboriginal or Torres Strait Islander background.

² The Ingham Foundation was established by a local businessman/philanthropist who made his fortune from the commercial sale of frozen chickens. The Foundation supports research activities within region's health services.

urban setting. Research published elsewhere has repeatedly demonstrated poorer health for Indigenous people compared to the general Australian population. This is reflected in a lower life expectancy, a greater burden of disease and a higher hospital separation rate (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 2001; Read, Gibbins, Stanley, Morich, 1994). Compared with non-Indigenous children of the same age, Indigenous children aged less than 12 months have lower birth weights (Australian Institute of Health and Welfare, 2002), slower growth (National Health Strategy, 1992; Cousham, Gracey, 1997), greater mortality (Alessandri, Chambers, Garfield, Vukovich, Read, 1999), higher hospital admission rates (Read, Gibbins, Stanley, Morich, 1994; Gracey, Gee, 1994) and are more frequently born prematurely (NSW Department of Health, 2002). These differences in health commence prenatally (National Health and Medical Research Council, 2000) and often continue across the lifespan. Adverse social and environmental conditions such as overcrowding, poor hygiene, environmental smoke and parental skills (Leach, Boswell, Asche, Nienhuys, Mathews, 1994; Wigg, Tong, McMichael, Baghurst, Vimpani, Roberts, 1998) are also common. These factors contribute to the exposure of infants to infectious diseases and cross-infection, resulting in the early onset, high prevalence and chronic of otitis media among Indigenous children (Boswell, Nienhuys, 1995; Torzillo, Pholeros, 2002; Harris, Kemien, 1990).

It is against this demographic profile that CHETRE based researchers determined to redress the shortfall in data on the health needs of the area's Indigenous children. In collaboration with the local Indigenous community and two Indigenous researchers from the UNSW funding was sought to undertake a birth cohort study of Indigenous children in the Campbelltown area and to follow them for one year. Funding was sourced in 2003. The next two years were spent identifying and engaging the various groups within the local Indigenous community with whom we would work. As will be discussed this was a lengthy process but well worth the time invested. We began the recruitment process in mid October 2005 and finished in early May 2007. We successfully recruited 159 babies from 152 mothers into the project (seven mothers gave birth to two babies within the 18 month recruitment period and both infants were included).

The aims of the Gudaga study are:

1. to establish how well Indigenous infants are identified through health services;

2. to describe the obstetric outcomes and health service use for mothers of Indigenous infants;
3. to describe the health, development and health service use of Indigenous infants aged 0-12 months; and
4. to identify issues participating mothers would like addressed to improve the health and wellbeing of themselves and their families.

These aims are operationalised in three ways. Firstly, we survey all mothers admitted to the maternity ward of Campbelltown Hospital following the birth of their child to identify babies with an Indigenous mother or father. This information will be used to extract routine antenatal data to compare mothers of Indigenous babies with mothers of non-Indigenous babies (Aims 1 and 2). Mothers of Indigenous babies are invited to participate in the study. Secondly, we visit the mothers and their babies at 2-3 weeks, six and twelve months, to complete a number of anthropometric measures (length, head circumference and weight) and a questionnaire on health status and health service use (drawn primarily from the NSW Child Health Survey and the WA Aboriginal Child Health Survey). At 12 months all participating babies are examined by a paediatric registrar (Aim 3). Finally we are documenting the stories of mothers' experiences using available health services (Aim 4). Collecting the stories will provide a qualitative component to the research and capture a richness so often lost in hard numbers.

Grounding the research in the community

Whether the researchers were aware of it or not, the years spent talking and dreaming on Tharawal's verandah built a spirit of equality, respect and reciprocity between themselves and the community's mothers, elders and health workers. It was imperative these values remained in place as we moved through every step of the research process including the building of the research team, identifying the community we would work with and then working with the various groups that make up that community. We continued to stay involved in the community and invest time during the establishment and implementation of the project.

Building the research team

In keeping with the project's ethos it was important the research team include Indigenous academics, with strong research backgrounds and the necessary technical expertise, as well as members of the local community. Unfortunately neither was readily available. In contrast to countries such as

New Zealand and Canada there is a shortage of skilled Indigenous health researchers in Australia as has been recognised by, for example, Henderson, Simmons, Bourke, Muir (2002). At the time of instigating this project there were no Indigenous health researchers at UNSW with an interest in public health. Fortunately, during the early days of the establishing the project, two academics joined UNSW and established Muru Marri Indigenous Health Unit and both were invited to join the research team. Neither of these researchers were from the local Indigenous community. They, like the other (non-Indigenous) researchers, had to earn the respect of those with whom we were working. CHETRE's longstanding relationship with the local community helped this process but it was not enough. The Indigenous researchers actively sought to earn the respect in little ways – by traveling long distances to attend community meetings, and by spending time talking with and engaging key Indigenous leaders.

Formalising community input was equally problematic and at times fraught. Even so, a major factor that facilitated this input was the active interest taken by several of the research team in concerns of the community and advocating for services over several years. In addition, considerable time was invested in negotiating and talking with local AHWs and managers encouraging them to become involved in the research. The negotiations were successful and, as will be discussed, Tharawal's CEO, and two of the most senior Indigenous health workers from the local Area Health Service agreed to be part of the research team. The research team is committed to working with each of these health workers to ensure their engagement is ongoing.

Identifying the Gudaga community

A basic premise of the study is that every facet of the research needed to be owned by the Indigenous community. That ownership cannot be an abstract concept; it has to be real. When determining what such involvement would mean in reality we realised we had to ask ourselves a rather basic question: "What is the Indigenous community?" We knew there are many different groups that make up the Indigenous community in south west Sydney and that involving this community would mean identifying and working across a spectrum of organisations and individuals. We also knew we could not assume any of the groups would want to be involved in our work.

We have identified at least four groups from the Indigenous community with whom we work. They include:

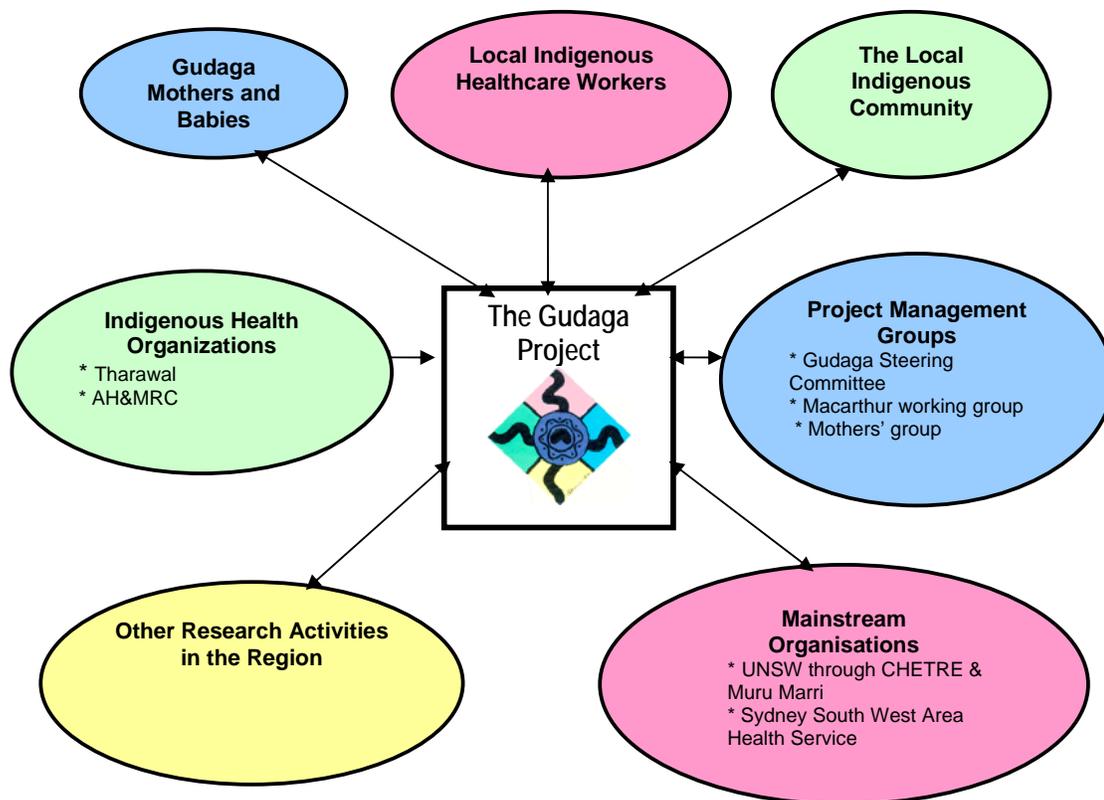
1. the Gudaga mothers and their babies;

2. the local Indigenous community of Campbelltown;
3. the local Indigenous healthcare workers; and
4. Indigenous health organisations.

There is also strong Indigenous representation on three other groups that are part of the Gudaga project. These three groups are:

5. project management groups;
6. mainstream academic and health organisations; and
7. other research activities in the region that have similar aims.

The relationship of these seven groups with the Gudaga project is depicted in Figure One below. As the following discussion will demonstrate, different strategies are required to work and maintain contact with each of these groups.



**Figure One
The Gudaga Community**

Figure One shows the extent to which we define “community”. The term is, obviously, not limited to the geographical boundaries that are the Campbelltown Indigenous community. Rather we have looked to community-based participatory research and defined “community” broadly as all those who will be affected by the research results which includes lay residents of the local area as well as practitioners, service agencies and policymakers (Green and Mercer, 2001).

Working with the Gudaga community

The scope and nature of these seven groups is exceptionally broad. Each requires different strategies for them to be engaged fully in the project. We have spent considerable time and energy identifying innovative strategies to work with each group.

Gudaga mothers and their babies

The Gudaga mothers are the lynchpin of this project. Without them, and their longterm commitment to the project, it would be impossible to maintain the cohort over time. Not surprisingly, the women come from a very diverse cross-section of the community. Some of them are young teenagers with their first baby, others are older women who already have three or four children. Some live in extreme poverty while others are financially secure. A few live in refuges and have a

different address every time we visit them while others live in very stable and comfortable homes. Some have a history of domestic violence, regular contact with illicit drugs and/or mental health concerns and vulnerable lifestyles.

We have been working with the mothers for almost two years now and over this time we have observed a growing commitment toward the project. This is evident in a number of ways. Quite regularly, mothers who move away make contact and let us know their new contact details or visit the Project Officers when they come back to the area visiting friends and relatives. This initiative of the mothers is ensuring that attrition is minimal. There is also a sense of enthusiasm amongst the mothers. Many appreciate the potential use of the project’s results and findings on the

future provision of health services. They see themselves as making a positive contribution to the research and take pride in this. Opportunities for the mothers to be actively involved in the study vary. There is, for example, limited opportunity for them to be involved in the actual design of the study as we are using well established instruments that have been validated over time. We anticipate a greater role for the mothers as we move into the data analysis stage. We will actively seek their input as results start to come through. We are planning to present the results to the mothers in a variety of ways: small group meetings, easy to read printed material and large community fora.

Over time our Project Officers are building strong links with the Gudaga mothers. The strength of these links was obvious at, for example, the death of one of the babies. One of Project Officers had visited the mother and baby just a few weeks before the death and had taken several photos. She went to the funeral and was able to give the photos to the mother – a simple gesture which meant a lot to the family.

The issue of trust is pivotal to Indigenous health research (Pyett, 2002). Some Indigenous researchers have contended trust has been “forever violated” by past research of indigenous communities (McKendrick & Bennett, 2003, p22). This has not been our experience. We are constantly astounded at the level to which participating mothers will confide in the Project Officers; the level to which they will disclose information over and above that which is sought through the structured survey questions asked of each mother. We originally decided against asking the mothers about their drug taking habits fearing this would be seen as too intrusive and we may not obtain accurate information. During the first few months of conducting the first round of interviews we found many mothers volunteered the information. On the basis of this experience we decided to include some questions on illicit drug use in the interview conducted at six months. Similarly mothers freely talk to the Project Officers of their experiences with domestic violence and financial stress.

We have always been very conscious of the importance of making the project a “win-win” for not only for the research team, but the mothers as well. Each time we make a home visit we leave a health pack with the mother as a thank you for her time. These packs include small token gifts for both mother and baby as well as information on age appropriate health issues such as SIDS (first home visit), transition to solids and immunisation (six month visit), and dental care (12 month visit). The packs also include a small contact telephone directory fridge magnet we have

designed which includes local phone numbers of frequently used health services as well as a photo of the baby. The Project Officer takes a photo of the baby at each home visit and it is given to the mother at the following visit. The photos are always well received as both the mothers and the research team delight in watching the babies grow and develop.

Many of the small gifts included in the health packs have been specifically designed to engender a sense of involvement in the project. At six months all babies receive a screen printed “I’m a Gudaga baby” t-shirt and at 12 months we give the babies a sunhat with the same wording. At this time the mothers receive a Gudaga coffee mug.

The local Indigenous community

A strength of cohort study design is the ability to promote the research within the Indigenous community. We have put in place a number of strategies to encourage visibility of the project. These include the choice of local Indigenous mothers to work on the project, opportunities to join a “mothers’ group” that is kept informed about the project, and the use of a project name and logo that are recognizable within the community.

We considered it imperative that the Project Officer positions be filled by local Indigenous mothers. We have employed two Project Officers. Both have young children and are very well known within the community. We are certain their strong links to the community are making a significant contribution to the success of the project. The recruitment of the project officers placed a high priority on Aboriginality, being a mother and being part of the local Indigenous community. Strong research experience was not considered essential. We have trained each project officer in a number of specific areas including interviewing techniques, conflict resolution, the importance for confidentiality, communication skills, and data management to assist them in their work. We have a capacity building program in place to build their project skills.

The project’s name is “Gudaga” which mean “healthy baby”. The name, suggested by local AHWs, comes from the local Tharawal language. Once we had a name we were keen to have a logo designed for us. Finding someone proficient in Indigenous art and logo design wasn’t easy but we eventually found a young man who put together some art work for us. When we showed his work to a group of mothers they immediately asked if the work had been designed by a woman. For these women, it was imperative any artwork concerning mothers and babies be designed by a woman. The search continued. After a number of weeks our Project Officer finally found a local Indigenous mum who created a

wonderful logo featuring Indigenous art that is rich in maternal/child symbolism. This time the mothers were delighted with her work and endorsed it as the project logo.



We were particularly keen to incorporate Indigenous art into the project. The idea is in keeping with our attempts to work with the community. But it is much more than that. For us,

the inclusion of Indigenous art is recognition of the cultural distinctiveness of Indigenous peoples and their right to enjoy that distinctiveness (National Health and Medical Research Council, 2006).

The logo is used extensively throughout the project. It is, for example, featured on all promotional material including posters and brochures that inform the community of the project. The posters are prominently displayed at the local hospital and Tharawal and brochures are distributed at the offices of local general practitioners, Tharawal, and given out by members of the Aboriginal Home Visiting Service. The logo is also featured on the shirts worn by staff and the gifts we give the mothers and babies. We anticipate measures such as these will engender a sense of project ownership within the community. The Gudaga mothers in particular already identify strongly with the logo and have pride in it and the project it symbolizes.

Local Indigenous healthcare professionals

Within the region there are a number of Indigenous healthcare professionals who are responsible for the health and welfare of Indigenous babies and their families. Some are employed by Tharawal while others work for the local area health service, either in Aboriginal Health or as part of the Aboriginal Home Visiting Service. We have attempted to involve these healthcare professionals in the project on a regular basis. All the healthcare professionals receive the project's monthly newsletter and a number are members of the Macarthur Working Group which meets monthly.

Our experience is that multiple communication strategies are needed to ensure Indigenous healthcare professionals, in particular, are aware of and understand what the project is doing and the implications of various constraints on what the project can and cannot do. Early on in the life of the project we found ourselves repeatedly reminding the local Indigenous healthcare professionals of what we could and could not do. There were times when possible misunderstandings could have arisen as they attempted to understand that the project was not able to actively support and

promote their work, nor could we provide them with the names of participating mothers. We spent a lot of time working with the healthcare workers, explaining why we couldn't undertake specific requests. Open communication and time resulted in a resolution of the issue and it has not been problem as the project has progressed.

Another issue related to the non-interventionist nature of the project, and coming to understand what this actually meant. As the project seeks to describe use of health care, we cannot actively intervene in the provision of health care for the project's mothers and babies. There have been times when the project officers have been asked questions of a medical nature during home visits. The project officers don't answer questions of this nature. There are several reasons for this strategy. Neither of the project officers are medically trained and are not in a position to provide any advice. Even if the project officers were healthcare professionals it is outside the scope of this style of study for them to provide advice. Our strategy is to refer the mother to Tharawal Medical Service or the Aboriginal home visiting team and for the mother to work with other Indigenous healthcare workers to obtain the care needed.

Indigenous health organisations

Formal contact with Indigenous health organisations early in the research design process is recommended both internationally (World Health Organisation) and nationally (National Health and Medical Research Council, 2002; National Health and Medical Research Council, 2006). For us, this has meant engaging and working with two Indigenous health organisations.

For consultation on health matters affecting Indigenous peoples, representative bodies in Australia have established that the primary point of contact should be the local Aboriginal Community Controlled Health Service (ACCHS) (National Aboriginal and Islander Health Organisation, 1989). Our local ACCHS is Tharawal Aboriginal Corporation which includes the local Aboriginal Health Service. It is, of course, a focal point of the area's local Indigenous community. It has a high profile within the community and its involvement in Gudaga is fundamental to the project's success.

From the outset the staff at Tharawal has played a key role in the project. The Corporation's CEO is an associate investigator to the project. The project's monthly bulletins are tabled at each Board meeting and members of the research team meet with the Board on a semi-regular basis to keep them informed of the project's progress. Wherever possible, project staff attend events hosted by Tharawal.

The second Indigenous health organisation we work with is the Aboriginal Health and Medical Research Council. This involvement is in line with all Australian based research projects working with Indigenous communities. Ethics approval was sought from the Council at the very outset of the project and we adhere strictly to the Council's annual reporting requirements.

Project management groups

Three groups have been established to assist in managing the project. These include a steering committee, a working group as well as a grassroots group made up of mothers and grandmothers from the local community.

The mothers' group meets on an *ad hoc* basis at Tharawal. It is a very informal gathering of mothers involved in the project as well as older women who have an interest in the work we are doing. We provide a light lunch for the mothers and spend time chatting casually with them about the project: the sorts of things we are noticing, any difficulties we are experiencing in accessing and retaining mothers. While the idea of such a group sounds helpful the group has, unfortunately, somewhat of a chequered history. We have had difficulty organising it to meet regularly as well as enthusing sufficient numbers of mothers to be actively involved. We remain committed to this idea for we consider this group to be very important. We are looking for ways to generate enthusiasm for the idea and plan to try combining our meeting time around opportunities for the women to interact and socialise as a group with the project providing tea/coffee and biscuits or a light lunch for all those attending. As the findings begin to emerge we want to discuss them first with the mothers and to listen their thoughts and ideas of the implications of the findings for themselves, the broader Indigenous community and the provision of health services.

In addition to the mothers' group two committees have been established to provide direction and advice to the project: the Gudaga steering committee (made up of the project's chief and associate investigators) and the Macarthur working group (made up of local healthcare professionals directly involved in the project such as the hospital's maternity ward director of nursing, members of the Aboriginal home visiting team and the paediatrician conducting the developmental assessments). These two provide the best opportunity for local Indigenous healthcare professionals to be actively involved in the project. We have ensured all relevant Indigenous healthcare professionals in the region are on one or other of these committees. These committees also give them

an opportunity to meet together to discuss the research and issues of common concern.

The Gudaga steering committee, made up of the study's chief and associate investigators, meets quarterly. The academic researchers are joined by the providers of Indigenous health services from the local area health service. This group gives overall direction, advice and support to the project. The steering committee meets at Tharawal and is chaired by Tharawal's CEO.

The Macarthur working group meets monthly. This group provides a venue for information exchange about various activities in the region of relevance to the Gudaga project. The group comprises a number of relevant Indigenous healthcare professionals including representatives from the Aboriginal Home Visiting Service, Tharawal, maternity ward staff and a hospital paediatrician. It is very operational in terms of the issues it considers and advice it provides.

Other research activities in the region

When the planning for this project began ten years ago there was little, if any Indigenous child health research activity in the region. Fortunately this is no longer the case and there are now two other research projects underway in the region. The Safe Koori Kids project is a three year project run by The George Institute and Yooroang Garang: School of Health Studies at the University of Sydney. It aims to develop a school, family and community based intervention around Indigenous child safety (The George Institute, 2005). A second project is statewide in nature though will recruit some participants through Tharawal. The Study of Environment of Aboriginal Resilience and Child Health (SEARCH) is based at the Sax Institute and plans to follow approximately 2000 urban Indigenous children from 800 families across NSW to explore the determinants of health and to trial strategies to improve health outcomes (The Sax Institute, 2006).

The Western Australia Child Health Study (Zubrick, Lawrence, Silburn, Blair, Milroy, Wilkes, Eades, D'Antoine, Read, Ishiguchi, Doyle, 2004) and the National Longitudinal Study of Indigenous Children (Penman, 2006) are two additional studies which, though not locally based, inform our research.

We are developing strategies to interact with these projects and have ongoing plans to share our experiences and study findings.

Mainstream organisations

Finally, we work with two organisations: one academic in focus, the other health. The project's academic base is UNSW which includes CHETRE and the Muru Marri Indigenous Health Unit. CHETRE, which is part of the University's Centre for Primary

Health Care and Equity, is a research and evaluation centre located in south west Sydney with a focus on disadvantaged communities. As has been discussed, CHETRE researchers have a long association with local AHWs and Tharawal staff and have long advocated for better health services for the area's Indigenous families. As the project's auspicing body CHETRE is Gudaga's "home".

The project has also drawn upon Muru Marri's professional staff with two of the Unit's members working as chief investigators on the project. They bring to the project, not only the professional rigour expected of academic staff, but Indigenous heritage and culture which adds authenticity and credibility to the project.

Our local area health service (Sydney South West Area Health Service) has been exceptional in the support it has provided the project: office space at Campbelltown hospital, the use of a car for the home visits and access to the paediatricians for the 12 month health and development assessments. Without this "in kind" support the project would struggle financially.

The take home lessons

The Gudaga project has begun well. We finished recruiting in April 2007 with 159 babies in the cohort, attrition has been minimal and the mothers are keen to participate. There is a strong sense of ownership of the project amongst the Gudaga mothers as well as within the local Indigenous community and considerable interest from academics and Indigenous health researchers further afield.

There are at least two take home lessons from the Gudaga project. Both are relevant to community based indigenous health research. The first relates to time. CHETRE first became involved in the Indigenous community of south west Sydney in 1997. The first results from Gudaga will start coming through in 2007 - ten years later. The ten years has been spent developing and nurturing respect, trust and reciprocity. The past decade has enabled the non-indigenous researchers to demonstrate to the local Indigenous community that they are prepared to make a commitment over a long period and they are not "fly-by-nighters": that they will advocate for the local Indigenous community; work with the community's agenda (rather than a pre-determined research agenda); and, if necessary, stand up to the bureaucracy on their behalf.

The second lesson relates to the values that underpin and sustain the project: trust, respect, reciprocity, a commitment to open communication and staying connected. None of these concepts are new. They lie "at the heart" (National Health and Medical Research Council, 2006, p8) of two key Australian based documents produced by the country's

peak research body, the NHMRC: *Strategic framework for improving Aboriginal and Torres Strait Islander health through research* (National Health and Medical Research Council, 2002), known as *The Road Map*; and *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research* (National Health and Medical Research Council, 2006). These two documents are foundational to those working in the area of Indigenous health research. Gudaga is demonstrating, in a very practical way, what it means to translate the values espoused in these documents into day to day reality.

In working with these values there is a tension with which we must attempt to reconcile regularly. We balance the need for robust descriptive, non-interventionist research of health issues with the ideals of action research including the timely feedback of findings. We are not prepared to compromise the scientific integrity of the study.

What began as a yarn on the verandah almost ten years ago has led to an environment of mutual trust and respect which in turn has led to a ready acceptance of the Gudaga project by the Indigenous community. But none of this can be taken for granted. The project needs to continue to involve every facet of the Indigenous community. The strategies identified and employed are essential to maintain trust and respect. The project remains committed to long term sustainability, the ongoing need for open communication, staying connected with all our stakeholders and feeding results back to the local Indigenous community in ways that are accessible and appropriate. This is the challenge that lies ahead for all of us involved in Gudaga as we work to ensure all infants within the Indigenous community of south west Sydney are indeed, healthy babies.

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Author Profiles

Jennifer Knight, BA (Hons), Dip Ed, MPH, PhD, is Gudaga's project manager. She is based at the Centre for Health Equity Training, Research and Evaluation (CHETRE) which is part of the University of NSW's Centres for Primary Health Care and Equity. She has also held research positions at the University of Sydney and Macquarie University.

Prior to entering the academic domain she worked in state politics for over ten years. Dr Knight was policy adviser to the NSW Minister for Health and Minister for Industrial Relations. She was also Director of the Legislative Council's Standing Committee on Social Issues, NSW Parliament where she headed inquiries into aboriginal representation in parliament, sexual violence, hepatitis C, adoption practices and rural suicide.

Jennifer lives with her husband and young son, James and Elliott Smith, in Sydney, Australia.

Elizabeth Comino, BVSc, MPH, PhD, is a senior research fellow at the University of NSW. In 2002 she was awarded a Churchill Fellowship to study primary care research in the UK. She is an epidemiologist interested in access to and use of quality primary health care. She works with the Centres for Primary Health Care and Equity, University of NSW and CHETRE, Liverpool Hospital. She leads a program of work at the Centres using population health data sets to provide information on use of primary health care.

Dr Comino has extensive experience in the conduct of research in community, general practice and community health settings. She has used a range of study designs including intervention and descriptive study designs to improve access to and quality of health care for children and adults with a range of health care conditions including diabetes, asthma (children and adults), chronic obstructive pulmonary disease, anxiety and depression, and chronic pain.

She has worked with the Aboriginal community in Macarthur since 2000 to support the establishment of the Aboriginal Home Visiting Team in the region and with Tharawal Aboriginal Corporation to support their activities. She is the lead investigator on the Gudaga Project. In developing and implementing this research she has worked closely with the Aboriginal Health Service, mainstream health services and the Tharawal Aboriginal Corporation.

Elizabeth Harris originally trained as a social worker. She has worked in community based health services in urban, provincial and remote parts of Australia as well as in several Pacific Island countries. For the past eight years she has been the Director of CHETRE at UNSW. Her research interests are in developing and researching the effectiveness of interventions to reduce health inequality in policy and practice areas.

Cheryl Anderson is Gudaga's full time project officer. She is an Indigenous woman who has spent most of her life living in Campbelltown where she is very active in the area's Indigenous community. She is the mother of four year old Catlyn.

Pippa Craig, BSc, DipNutrDiet, MHPEd, PhD, has worked on projects for improving services for and researching with the local Aboriginal community in South Western Sydney since 2000. She is a Chief Investigator on the Gudaga project. Dr Craig was involved in the establishment of the Aboriginal Home Visiting project which aims to address risk factors for conditions of high prevalence among urban Aboriginal children and to develop strategies to address these. She was also involved in another project that aimed to increase the use of primary health care services by the urban Aboriginal community in South Western Sydney. Outcomes were a package of Indigenous educational resources for local GPs, and a forum in which the local Aboriginal Controlled Health Service, local health services and GPs identified priority areas for future collaboration.