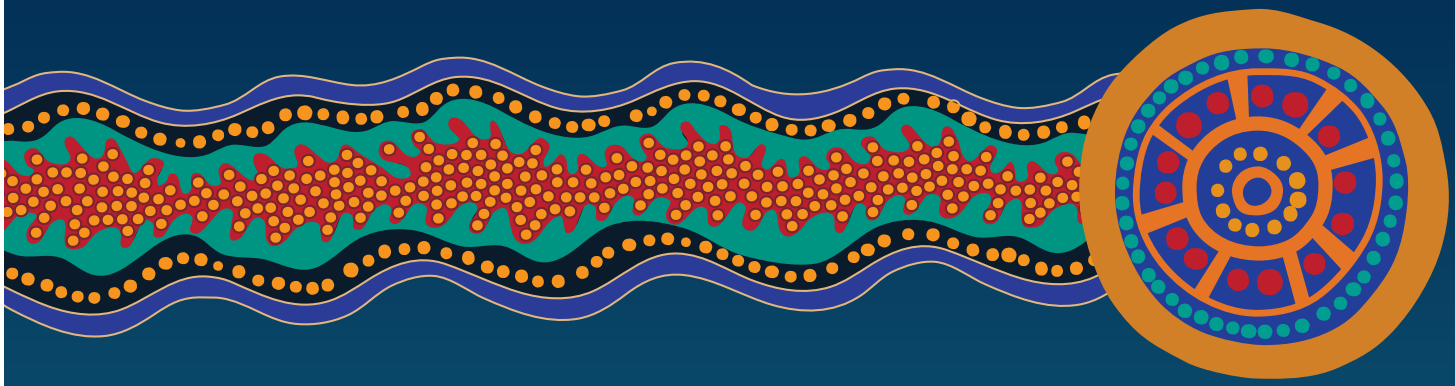

Making Tracks Together

Queensland's Statewide First Nations Health Equity Strategies Monitoring and Evaluation Framework

Supporting learning and accountability in health equity reform

AUGUST 2024

QAIHC
Queensland Aboriginal and Islander Health Council

Queensland Government

Making Tracks Together

Monitoring and Evaluation Framework
(AUGUST 2024)

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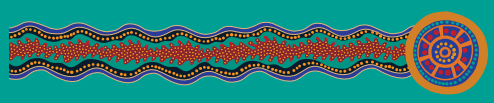


Making Tracks Artwork produced by Gilimbaa for Queensland Health

SC2400612

Acknowledgement of Country

Queensland Health respectfully acknowledges the Traditional and Cultural Custodians of the lands, waters, and seas across Queensland. We pay our respects to Elders past and present, while recognising the role of current and future leaders in shaping a better health system. We value the culture, traditions, and contributions that the Aboriginal and Torres Strait Islander peoples have made to our communities and recognise that our collective responsibility as government, communities and individuals is to ensure equity and equality, recognition, and advancement of Aboriginal and Torres Strait Islander peoples in Queensland in every aspect of our society. Queensland Health acknowledges the First Nations people in Queensland are both Aboriginal and Torres Strait Islander peoples, and supports the cultural knowledge, determination, and commitment of Aboriginal and Torres Strait Islander communities in caring for their health and wellbeing.

Making Tracks Together: Queensland's Statewide First Nations Health Equity Strategies Monitoring and Evaluation Framework was guided by the wisdom and expertise of Aboriginal and Torres Straits Islander peoples and partners across the health and wellbeing continuum.

Aboriginal and Torres Strait Islander peoples are advised that this publication may contain the names and/or images of deceased peoples.

Terminology

Throughout the framework, the terms 'First Nations peoples' and 'Aboriginal and Torres Strait Islander peoples' are used interchangeably rather than 'Indigenous'. Acknowledging First Nations peoples' right to self-determination, Queensland Health and the Queensland Aboriginal and Islander Health Council respect the choice of Aboriginal and Torres Strait Islander people to describe their own cultural Identities, which may include these or other terms (for example, Meanjin Brisbane).

Contents

A message from the Director-General and Chief First Nations Health Officer

Our healthcare system supports individuals in their health and wellbeing journey, providing access to quality care, in all settings and across all stages of life.

However, we know that good health is not shared equally across our diverse community, demonstrating the need for our health system to deliver safe, responsive, and person-centred care for all Queenslanders, including our First Nations community members.

The health inequities First Nations people in Queensland experience are still very much a reality for our communities. Recent data released by the Australian Bureau of Statistics demonstrates that we must do more to improve the health and wellbeing of First Nations people in our state. Recent statistics tells a story that children born between 2020 and 2022 will still live comparatively less than their non-First nations peers (7.4 years less for males and 7.0 years less for girls). Those who live in remote and disadvantaged areas continue to experience even worse health outcomes and considerably bigger gaps in life expectancy than other Australians from similar regions.

Our First Nations health equity reform agenda was introduced into our health system in Queensland in 2020 with amendments successfully made to the laws that govern our Hospital and Health Services, prescribing how Hospital and Health Services will work with First Nations stakeholders through their health equity strategies.

We are proud that all 16 Hospital and Health Services have publicly released their inaugural, Board approved health equity strategy and have commenced their first three-year implementation cycle.

These strategies show a real commitment from our Hospital and Health Services in realising health equity in their regions. It is also a means for our communities to hold our health services accountable in ensuring that the healthcare being delivered is designed with them to ultimately achieve health parity.

These legislative changes are the first of its kind for our country. Therefore, it is essential that we take time to evaluate and assess the impact it is having on our health system. Over the coming years, this monitoring and evaluation framework will provide the mechanism to determine if health equity has been achieved in our health system, institutional racism has been eliminated and the health and wellbeing outcomes of First Nations people in Queensland has been achieved at a population level. Ultimately, it will be able to demonstrate if legislation can have a positive impact for First Nations people after generations experiencing and living under legislation that restricted their health and wellbeing.

Queensland Health is committed to improving the lives of First Nations people living in Queensland. We deeply value and celebrate the unique culture that both our Aboriginal and Torres Strait Islander communities bring to the great state of Queensland. Our ongoing commitment and work that we do now and into the future will continue to create an integrated health system in Queensland that sees more First Nations peoples employed across the system, listens to First Nations voices in the system, supports a better integrated and coordinated system for First Nations peoples; and is a more equitably funded system.

Michael Walsh
Director-General, Queensland Health

Haylene Grogan
Chief First Nations Health Officer

A message from Matthew Cooke, Chairperson QAIHC

Our mission is to advance health equity and, eliminate racism in the public health system by *Closing the Gap* in health outcomes by 2031.

The legislation passed by the Queensland Parliament in 2020 and 2021 to require our Hospital and Health Services to develop health equity strategies is an important symbol of our shared commitment to reaching these goals. Queensland's Hospital and Health Services have made good progress to co-develop and co-implement health equity strategies.

But we must ensure the strategies are more than symbolism. We must make clear-eyed assessments of health equity strategies and their implementation to ensure First Nations people receive the health care they deserve without experiencing racism. This assessment must be made through the lens of community. This framework will guide the monitoring and evaluation of health equity strategies, giving Queensland a transparent way of assessing whether they are being implemented in ways that make a real difference.

With monitoring and evaluation data we can change implementation approaches when needed to achieve greater impact. We can also identify and share successful approaches and interventions allowing us to share learnings about the best ways of achieving health equity.

By providing a robust framework for assessing whether health equity strategies are achieving their aims, we create the ability to change and adapt health interventions to meet the needs of First Nations people and communities. We also create opportunities to guide the health investments to where they contribute most to achieving health equity, promoting accountability, transparency and consistency of funding, and investment in community-controlled approaches.

QAIHC hopes the monitoring and evaluation framework will strengthen the development and continuous improvement of collaborative, evidence-based health equity strategies, and transparency about the outcomes they achieve.

Only by bridging the health gaps between Indigenous and non-Indigenous Australians within our communities, can we achieve health equity. Our people, our communities, know what is required and how to make this happen, and this monitoring and evaluation framework must support the community voice.

The First Nations health equity agenda must continue to be a collective effort to transform health outcomes for Aboriginal and Torres Strait Islander peoples informed by our people through genuine co-design and community-controlled approaches.

Together, let's work to create a future where health equity is not just an aspiration but reality for our people and communities.

QAIHC
Queensland Aboriginal and Islander Health Council

Matthew Cooke
Chairperson QAIHC

Introduction and context

1

Health equity reform

The First Nations health equity reform agenda aims to galvanise a renewed and shared agenda to improve Aboriginal peoples' and Torres Strait Islander peoples' health outcomes, experiences, and access to care across the health system.

This agenda builds on the foundations of the past to reshape the health system by placing 'health equity' and Aboriginal and Torres Strait Islander voices at the centre.

The success of this new approach is dependent on representation, leadership and shared decision-making with Aboriginal peoples and Torres Strait Islander peoples.

It will only succeed by listening to and respecting the voices, lived experiences and cultural authority of Aboriginal and Torres Strait Islander peoples.

Making Tracks toward closing the gap in health outcomes for Indigenous Queensland by 2033: Policy and Accountability Framework (Making Tracks) has provided an evidence-based policy framework to achieve health parity with First Nations peoples across the lifespan and health service continuum since 2010. Programs to address specific health issues, support health promotion, and deliver more culturally responsive models of care are supporting health gains however, additional system reform is necessary to accelerate success in achieving health equity and realising the *National Agreement on Closing the Gap* targets by 2031.

The 2017 report *Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services*, identified high levels of institutional racism across the public health system, causing First Nations peoples to experience disparities and inequities in accessing health services, in their experiences of health services, and subsequently in their health outcomes. The Queensland Government prioritised First Nations health by establishing a First Nations Health Office (formerly the Aboriginal and Torres Strait Islander Health Division) and the role of the Chief First Nations Health Officer (formerly the Chief Aboriginal and Torres Strait Islander Health Officer) within Queensland Health. Prioritisation of First Nations health and health equity was further galvanised with the passing of legislation that substantively changed the structures, systems, and strategies of the public health system in Queensland. This included the legislative requirement for each Hospital and Health Service (HHS) to:

- Ensure Aboriginal and Torres Strait Islander peoples represent one or more of the members of a *Hospital and Health Service Board (Section 23(4) HHB Act)*.
- Develop and publish a strategy to achieve, and to specify the Service's activities to achieve, health equity for Aboriginal and Torres Strait Islander peoples in the provision of the health services by the *Service (Section 40(1)(c) HHB Act)*.

The Hospital and Health Boards Regulation (2023) specifies the minimum requirements for the HHSs in developing and implementing their health equity strategies in relation to:

- the prescribed stakeholders
- consultation processes
- priority areas.

Extensive co-design and community consultation processes informed the selection of the health equity strategy's five priority areas.

Making Tracks Together: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework (Making Tracks Together) outlines the strategic framework to drive health equity, eliminate institutional racism across the public health system, and achieve life expectancy parity for First Nations peoples by 2031. It provides the policy settings, strategic directions, and a toolkit to support the 16 HHSs to co-design, co-implement, and co-monitor their health equity strategies in partnership with Aboriginal and Torres Strait Islander Community-Controlled Health Services, other healthcare providers and prescribed stakeholders.

All 16 HHS health equity strategies have been launched and are now being implemented. The strategies all share the legislated priority areas, however, each HHS is following a unique path to health equity influenced by the significant differences in their geographic, relational, and organisational contexts.

Health equity strategies priority areas:

1. Actively eliminate racial discrimination and institutional racism within the service
2. Increasing access to healthcare services
3. Influencing the social, cultural and economic determinants of health
4. Delivering sustainable, culturally safe, and responsive healthcare services
5. Working with Aboriginal people, Torres Strait Islander people and Aboriginal and Torres Strait Islander communities and organisations to design, deliver, monitor and review health services.

The purpose of the framework

The *Making Tracks Together: Queensland's Statewide First Nations Health Equity Strategies Monitoring and Evaluation Framework (Health Equity Strategies Monitoring and Evaluation Framework)* moves equity reform forward by guiding a system-level assessment of the effectiveness and impact of the health equity strategies to expedite success. Three system-level, independent external evaluations will be conducted at regular points leading up to the 2031 timeframe to achieve life expectancy parity for First Nations people. The experiences and findings from each of the 16 HHSs will be integrated into these evaluations.

The purpose of the system level evaluations is to understand the collective benefit of health equity strategies and the effectiveness of the legislation (Hospital and Health Board Act, Hospital and Health Board Regulation and Health Service Directive) in driving systemic change. The system level evaluations will also facilitate the learning and transformation of HHSs to achieve health equity with First Nations peoples consistent with their health aspirations.

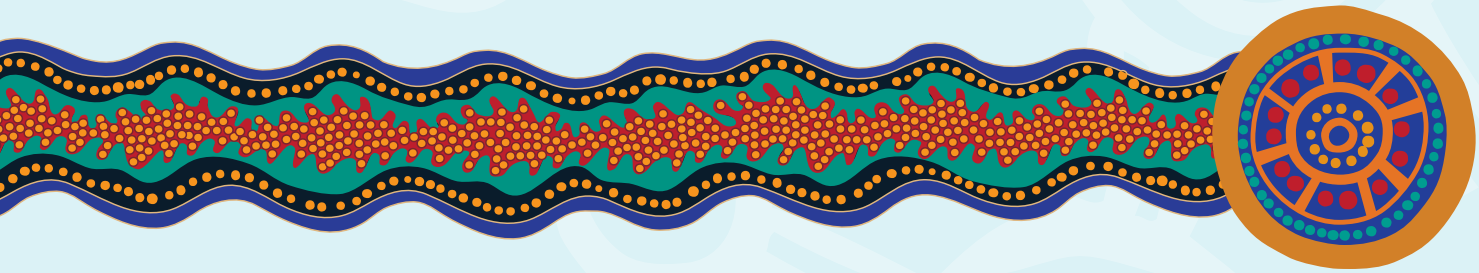
There are legislative requirements for each HHS to review their individual health equity strategies within 3 years of their release and every 3 years after that. Amended health equity strategies must then be published in a way that allows it to be accessed by the public.

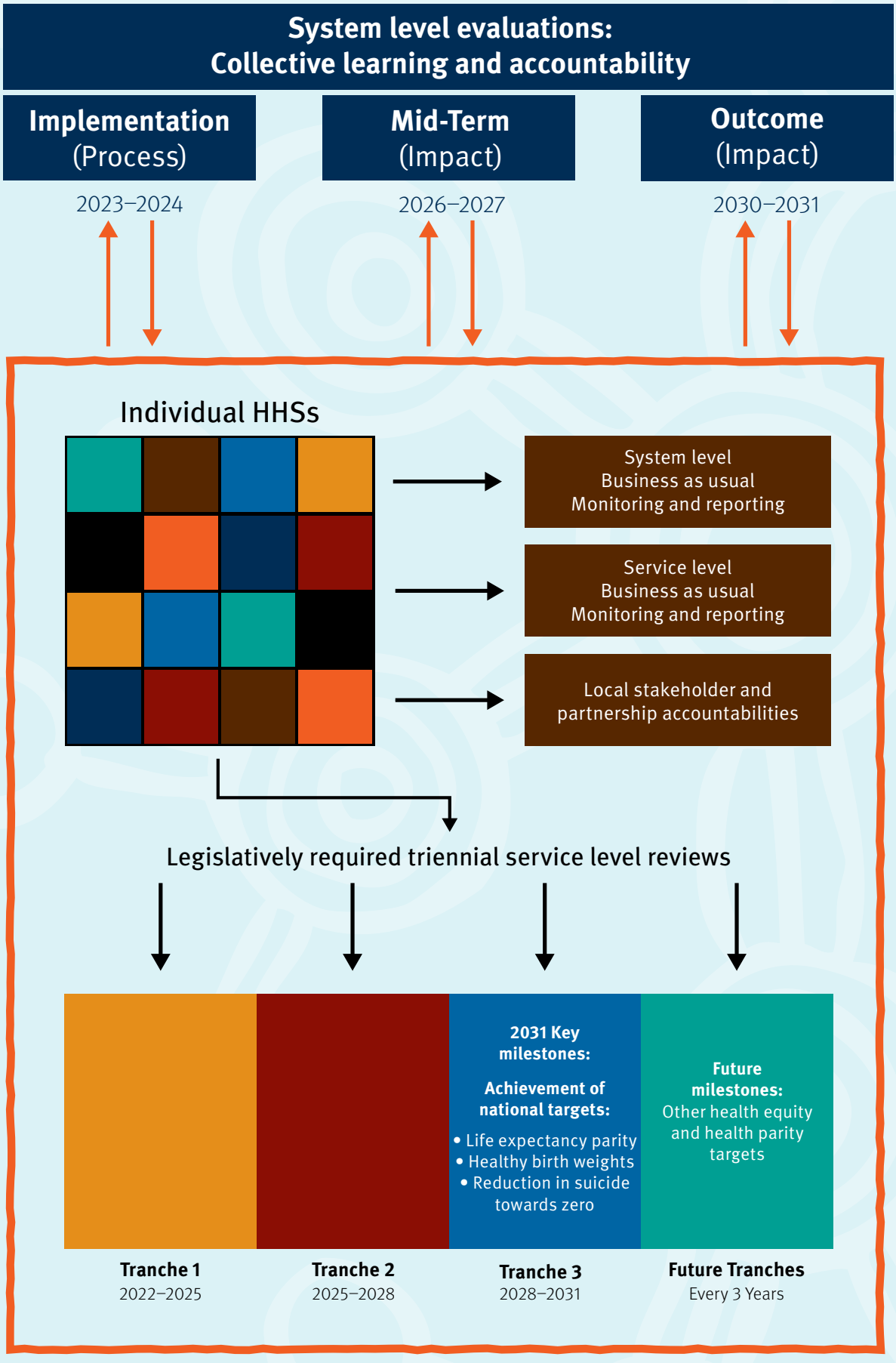
The *Health Equity Strategies Monitoring and Evaluation Framework's* 3 system level evaluations will support and supplement the individual service review processes by bringing together their experiences and outcomes to facilitate learning, translation, and adaptation across the system to achieve health equity. The evaluations will not duplicate the individual HHSs ongoing monitoring and reporting activities and requirements of their individual health equity strategies. Instead, they provide spaces for collaborative inquiry and system level learning.

The *Health Equity Strategies Monitoring and Evaluation Framework* covers the 3 system level evaluation cycles providing guidance on what needs to be evaluated and the parameters of the approach at these multiple time points. The primary audience for the evaluations will be Queensland Health, the 16 HHSs, the prescribed stakeholders, and First Nations communities.

This document provides:

- The background and context of the *Health Equity Strategies Monitoring and Evaluation Framework* (section 1)
- The *Health Equity Strategies Monitoring and Evaluation Framework's* objectives, logic, evaluation questions and approach (section 2)
- Information on operation of the *Health Equity Strategies Monitoring and Evaluation Framework* (section 3)
- Legislated or guiding definitions of key concepts and references (section 4).




System level evaluations:
Collective learning and accountability
Implementation (Process)
Mid-Term (Impact)
Outcome (Impact)
2023–2024
2026–2027
2030–2031
Individual HHSs
System level
Business as usual
Monitoring and reporting
Service level
Business as usual
Monitoring and reporting
Local stakeholder and partnership accountabilities
Legislatively required triennial service level reviews
2031 Key milestones:
Achievement of national targets:
• Life expectancy parity
• Healthy birth weights
• Reduction in suicide towards zero
Future milestones:
Other health equity and health parity targets
Tranche 1
2022–2025
Tranche 2
2025–2028
Tranche 3
2028–2031
Future Tranches
Every 3 Years

Policy context

The development, implementation, and evaluation of the health equity strategies, occurs in a dynamic and interdependent policy context. National and state level policies relating to primary, secondary and tertiary care, aged and disability care, preventative health, and the health workforce influence the broader health system.

Closing the Gap

The National Agreement on Closing the Gap is a partnership agreement between all Australian governments and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations. The aim of *The National Agreement on Closing the Gap* is to develop and implement policies and programs that overcome the entrenched inequities experienced by Aboriginal and Torres Strait Islander people to achieve parity in life outcomes. Nineteen socio-economic outcomes assess progress. Three of these are health specific:

- **Everyone enjoys long and healthy lives.**
- **Children are born healthy and strong.**
- Children are engaged in high quality, culturally appropriate early childhood education in their early years.
- Children thrive in their early years.
- Students achieve their full learning potential.
- Students reach their full potential through further education pathways.
- Youth are engaged in employment or education.
- Strong economic participation and development of people and their communities.
- People can secure appropriate, affordable housing that is aligned with their priorities and need.
- Adults are not overrepresented in the criminal justice system.
- Young people are not overrepresented in the criminal justice system.
- Children are not overrepresented in the child protection system.
- Families and households are safe.
- **People enjoy high levels of social and emotional wellbeing.**
- People maintain a distinctive cultural, spiritual, physical and economic relationship with their land and waters.
- Cultures and languages are strong, supported and flourishing.
- People have access to information and services enabling participation in informed decision-making regarding their own lives.

> *No individual socio-economic target exists in isolation when considering the Aboriginal and Torres Strait Islander holistic concept of health. However, 3 specific health targets have been included in the National Agreement on Closing the Gap (2020):*
>
> - *Close the gap in life expectancy within a generation by 2031.*
> - *By 2031, increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91%.*
> - *Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero.*

National Agreement on Closing the Gap (2020)

Progress against these targets is reported nationally through the Productivity Commission's national data dashboard. The Queensland Government also reports on state level implementation and progress against the targets. Achieving these targets requires governments to fundamentally change how they work with Aboriginal and Torres Strait Islander people and communities. Four priority reforms underpin *The National Agreement on Closing the Gap* targets to drive the necessary change.

National Agreement on Closing the Gap Priority Reforms and Government Actions	
Priority Reform 1 *Formal partnerships and shared decision making*	• acknowledge the shared decision making structures Aboriginal and Torres Strait Islander people have already developed and build on these successes • commit to establishing policy and place-based partnerships to respond to local priorities • review existing partnership arrangements to assess how they meet the partnership elements • include the outcomes of the review in annual reports.
Priority Reform 2 *Building the community-controlled sector*	• commit to building strong Aboriginal and Torres Strait Islander community-controlled sectors and organisations in line with the strong sector elements • include in annual reports information on actions taken to strengthen the community-controlled sector • implement measures to increase the proportion of services delivered by Aboriginal and Torres Strait Islander organisations.
Priority Reform 3 *Transforming government organisations*	• identify and eliminate racism • embed and practice meaningful cultural safety • deliver services in partnership with Aboriginal and Torres Strait Islander organisations, communities and people • increase accountability through transparent funding allocations • support Aboriginal and Torres Strait Islander cultures • improve engagement with Aboriginal and Torres Strait Islander people.
Priority Reform 4 *Shared access to data and information at a regional level*	• share available, disaggregated regional data and information with Aboriginal and Torres Strait Islander organisations and communities on *Closing the Gap*, subject to meeting privacy requirements • establish partnerships between Aboriginal and Torres Strait Islander people and government agencies to improve collection, access, management and use of data, including identifying improvements to existing data collection and management • make data more transparent by telling Aboriginal and Torres Strait Islander people what data they have and how it can be accessed • build capacity of Aboriginal and Torres Strait Islander organisations and communities to collect and use data.

The priority reforms are central to *The National Agreement on Closing the Gap* and directly informed by Aboriginal and Torres Strait Islander people. The reforms outline the structural changes governments need to make in the way they work with Aboriginal and Torres Strait Islander people to close the gap. health equity strategies must be consistent with the transformative elements of these priority reforms if they are to be effective in achieving health parity for First Nations people in Queensland.

National health policies

A number of national health policies have been developed to realise the goals of *The National Agreement on Closing the Gap* that influence the development and implementation of health equity strategies. These policies include the *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* and the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031*. The documents outline the requirements and commitments of actors in the health sector and the education and training pipelines. These requirements are reflected and operationalised in state level policies and strategies.

Queensland government policies

The Queensland Government's commitment to ***Closing the Gap*** is reflected across a number of regulatory and strategic policies. From a health perspective, these policies include direct commitments in the *Closing the Gap Implementation Plan*, the *Statement of Commitment to Reframe the Relationship between Aboriginal and Torres Strait Islander Peoples and the Queensland Government (Reframing the Relationship)*, and the *Hospital and Health Boards Act (2011)* ***and*** *Hospital and Health Boards Regulation (2023)*.

Mandating the need for HHSs to ensure participation of First Nations people in the design, delivery, monitoring and review of healthcare services aims to ensure the deliver of responsive, capable, and culturally competent healthcare. Changes to the HHSs *Service Agreements* and the *Queensland Health Performance and Accountability Framework* have also been made to support reporting, monitoring and accountability across the system.

HEALTHQ32: A vision for Queensland's health system further reinforces the commitment to improving the health and wellbeing of First Nations people in Queensland. First Nations health is one of the seven system priorities with a commitment to reform that places First Nations peoples at the centre of healthcare design and delivery in Queensland.

HEALTHQ32 – First Nations First Strategy 2032 will accelerate the reform efforts required over the coming years to achieve excellence in care and health equity with all First Nations people in Queensland. This will be achieved by focusing efforts in four focus areas: eliminate racism, re-shape the system, transform care and strengthen the workforce.

The Health Equity Strategies Monitoring and Evaluation Framework must ensure the activities undertaken by the HHSs as part of the health equity reform agenda are compliant with legislative requirements and contribute to coherence, alignment, and integration with other policy initiatives as part of a whole-of-society approach under the National Agreement on Closing the Gap at both state and national levels.

About the framework

Objectives and scope

Our goal

For First Nations people in Queensland to attain their full health potential as a result of equitable service delivery across the 16 HHSs and ensure no one is disadvantaged from achieving this potential because of their social position or other influencing circumstances.

The *Health Equity Strategies Monitoring and Evaluation Framework* provides guidance for the 3 system-level assessments of the effectiveness and impact of the health equity strategies in achieving their goal. The assessments will be conducted at regular points leading up to the 2031 timeframe and include an implementation evaluation, a mid-term evaluation, and an outcomes evaluation.

Monitoring, reporting, and reviewing the individual health equity strategies is already embedded into the governance arrangements of the individual HHS and the *Queensland Health Performance and Accountability Framework*. The *Health Equity Strategies Monitoring and Evaluation Framework* provides the structure to bring together the collective learning from performance monitoring and individual HHS reviews, to generate deeper insights and widen the analytic lens to the system level. The 3 evaluation points provide opportunities to drive adaptation along the path to equity as a form of continuous quality improvement.

The evaluations are collaborative spaces of inquiry, assessing and explaining the progress and impact of the health equity strategies to reorient the health system and achieve health equity with First Nations people in Queensland. Through this collaborative, iterative, and system level approach, the *Health Equity Strategies Monitoring and Evaluation Framework* will:

- determine the effectiveness of legislation on effecting systemic change
- strengthen accountability across the public health system
- assess progress on addressing health inequities
- evaluate the appropriateness and effectiveness of the priority areas at scale
- identify the facilitators, inhibitors, and changes required at different levels of the system to achieve health equity in service delivery for First Nations peoples
- provide timely evidence to support the continuous improvement of health equity strategies
- promote system learning and adaptation
- assist in demonstrating value for money and provide a basis for future funding decisions
- strengthen First Nations leadership in evaluation
- ensure that First Nations communities can articulate their needs and aspirations
- support informed policy, planning and decision-making to enable improvements
- contribute to coherence, alignment, and integration with other legislative and policy requirements at state and national levels.

The *Health Equity Strategies Monitoring and Evaluation Framework* supports the movement to best practice in service delivery. Improved service delivery supports First Nations peoples to attain their full health potential.

How the framework was developed

The *Health Equity Strategies Monitoring and Evaluation Framework* has been developed through a co-design process guided by the voices, lived experiences, and cultural authority of First Nations peoples. A governance group, comprising 95% First Nations representation from prescribed stakeholders oversaw the co-design process.

The development process was guided by *Indigenous Evaluation Guidelines* and incorporated:

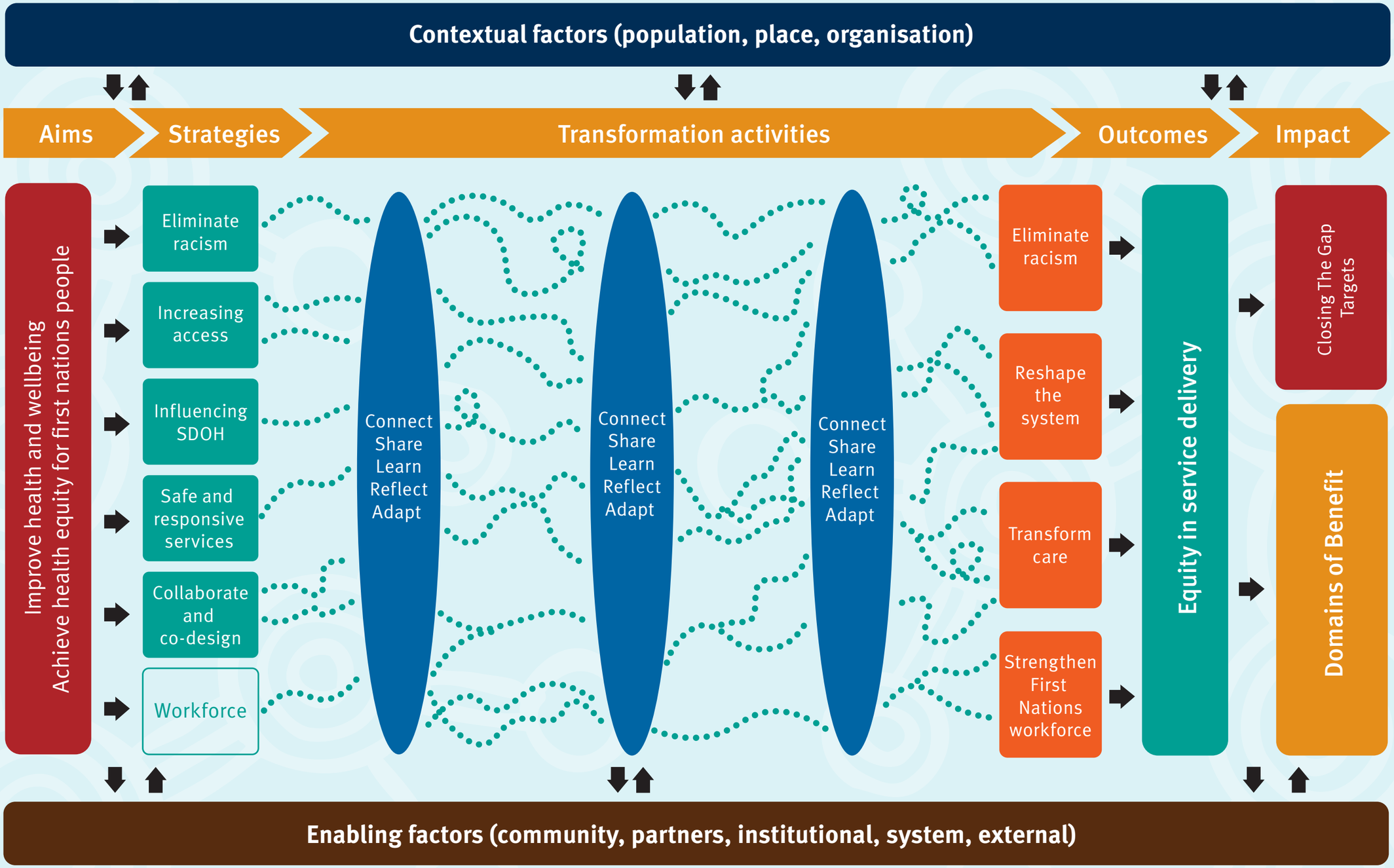
- legislative and regulatory requirements through a review of key policies
- First Nations consumer and community voices through an analysis of each of the *Making Tracks Together Consumer Consultation Reports*
- yarns with governance group members
- analysis of the HHS health equity strategies and associated implementation plans
- feedback from the governance group and other stakeholders.

Program logic model

The program logic model is a visual representation of how health equity reform should work. A logic model provides an abstraction of what happens (outcomes and impact) because of the interactions between the context and the activities in a program of work. It provides the basis for the evaluation questions and approach.

The ***Health Equity Strategies Monitoring and Evaluation Framework's*** program logic model illustrates the legislated aims and priority areas; the expected outputs, outcomes, and impacts; and the influence and interaction with the contexts and enablers across the evaluative cycles. The ***Health Equity Strategies Monitoring and Evaluation Framework's*** program logic model reflects:

	The importance of contextual factors (population, place, and organisation) for each of the 16 HHSs, which must be considered in relevance to the development, implementation, outcomes and impact of their health equity strategies.
	The National Agreement on Closing the Gap aims and outcomes.
	Legislatively required priority areas and outcomes. The 5 priority areas prescribed by *Making Tracks Together* as solid green blocks. The decision by some HHSs to separate workforce is reflected in the model also.
	The multiple, non-linear pathways from each priority area reflect the different actions the 16 health equity strategies have adopted to respond to local contexts and the movement or adaptation that will occur between the system-level evaluations from service-level review processes.
	The *Health Equity Monitoring and Evaluation Framework*'s 3 system-level evaluations are illustrated as places of connection, sharing, learning, and adaptation to reflect the framework's PAR approach.
	Transformation and benefits realised.
	Consideration of enabling factors at the service, system, sector, and community levels.
	The implementation of the health equity strategies should drive systemic change that contributes to and is consistent with the *HEALTHQ32* system outcomes.


Contextual factors (population, place, organisation)
Aims
Strategies
Transformation activities
Outcomes
Impact
Improve health and wellbeing
Achieve health equity for first nations people
Eliminate racism
Increasing access
Influencing SDOH
Safe and responsive services
Collaborate and co-design
Workforce
Connect
Share
Learn
Reflect
Adapt
Connect
Share
Learn
Reflect
Adapt
Connect
Share
Learn
Reflect
Adapt
Eliminate racism
Reshape the system
Transform care
Strengthen First Nations workforce
Equity in service delivery
Closing The Gap Targets
Domains of Benefit
Enabling factors (community, partners, institutional, system, external)

Evaluation questions

The evaluation questions for the *Health Equity Strategies Monitoring and Evaluation Framework* are based on the program logic for the health equity strategies and have been designed to:

- synthesise the knowledge and insights gained from the monitoring, reporting, and review mechanisms from each HHS
- consider the effect of place, organisational contexts, and system level influences
- draw on the requirements and values of relevant legislation, policy, and formal partnerships to ensure coherence, relevance, and flexibility across the life of the framework.

Whilst the program elements remain consistent across the 3 evaluations, the questions are adapted to reflect the movement from process to impact evaluations and the dynamic nature of the strategies. This approach maximises evaluation fidelity, relevance, and application of findings.

	System level evaluations: Collective learning and accountability		
	Implementation (Process)	*Mid-Term (Impact)*	*Outcome (Impact)*
	2023–2024	*2026–2027*	*2030–2031*
Question focus	**Process evaluation**	**Impact evaluations**	
Context	The influence of place-based, institutional, and system influences on the design and initial implementation of the health equity strategies.	The influence of emergent contextual changes in local, system, and socio-economic environments on health equity reform progress.	
Process	The fidelity of the design and initial implementation process to legislative, policy and relational requirements.	The fidelity of implementation, review, and adaptation to ongoing or emergent legislative, policy and relational requirements.	
Outputs	The consistency of the health equity strategies with the needs and goals of the community, stakeholders, and broader system.	The consistency of health equity strategy outputs with the needs and goals of the community, stakeholders, and broader system.	
Outcomes	The extent to which the design and initial implementation of the health equity strategies in achieving the intended outcomes and identification of unintended outcomes.	The extent to which the health equity strategies are achieving the intended outcomes and identification of unintended outcomes.	
Impact	The impact of the design and initial implementation of the health equity strategies as well as consideration of their intended mechanisms of impact, success factors, and sustainment.	The impact of the health equity strategies, success factors, sustainment and opportunities to expedite or increase health and social gains and system transformation.	
Return on investment	Enhancing the potential to assess the return on investment from the health and social benefits realised from the health equity strategies.	Assessing the return on investment from the health and social benefits realised from the health equity strategies.	

The evaluation questions should be applied with the goal of empowerment through learning and transformation. This requires a critical stance of looking back and then looking forward. In addressing each question, evaluators must first delve into what has occurred, and the reasons behind it, then determine the appropriate course of action for response, adaptation, or change. The questions are outlined on the following pages and a detailed guide for evaluators to address them is included in Section 3.

What has happened, and why?

What needs to happen now?

How will we know the health equity strategies are eliminating racial discrimination and institutional racism?

The health equity strategies are one of the actions the Queensland Government has put in place to address institutional racism in Queensland's Hospital and Health Services since receiving the 2017 report *Addressing Institutional Barriers to Health Equity*. Eliminating racial discrimination and institutional racism is one of the five priority areas legislatively required in each health equity strategy.

The *Health Equity Strategies Monitoring and Evaluation Framework* will assess progress in addressing institutional racism in a number of ways:

- Specific consideration of the priority areas in the health equity strategies **(Evaluation questions 3 and 8)**.
- Evaluation of changes using the transformation elements from *The National Agreement on Closing the Gap* priority reforms and *Reframing the Relationship* **(Evaluation questions 4 and 6)**.
- Evaluation of changes in institutional behaviour, processes, and context **(Evaluation questions 2, 9, 12, 13, and 14)**.

		Evaluation 1 (Implementation)	Evaluation 2 (Mid-term impact)	Evaluation 3 (Outcomes)
Context	**1**	What contextual factors influenced the design of the health equity strategies, and how will the activities under each priority area respond to them to achieve equity in service delivery and health outcomes?	What contextual changes have impacted the health equity reform agenda, and how have the activities under each priority area responded to them to achieve equity in service delivery and health outcomes?	What contextual changes have impacted the health equity reform agenda, and how have the activities under each priority area adapted to them to ensure equity in service delivery and health outcomes?
	2	How did institutional understanding and commitment to addressing health equity influence the design and implementation of health equity strategies?	How has institutional understanding and commitment to addressing health equity changed, and with what effect?	How has institutional understanding and commitment to addressing health equity changed, and with what effect?
Process	**3**	How were the activities under each priority area identified and decided by the co-design group, and with what effect? To what extent were there opportunities for innovation or influence by stakeholders? What influence did existing programs, initiatives, or alliances to improve health outcomes for First Nations peoples have on the development of Health Equity Strategies?	Not applicable	Not applicable
	4	How did the health equity strategies co-design processes uphold the legislative requirements, the principles of ***Making Tracks Together***, and the Queensland Government's commitment to reframing the relationship with First Nations peoples? What effect did this have on decision-making and implementation?	How have the health equity strategies upheld the legislative requirements, the principles of ***Making Tracks Together***, and the Queensland Government's commitment to reframing the relationship with First Nations peoples, and to what effect?	How have the health equity strategies upheld the legislative requirements, principles of ***Making Tracks Together***, and the Queensland Government's commitment to reframing the relationship with First Nations peoples, and to what effect?
Outputs	**5**	What governance, monitoring, and accountability arrangements were adopted to oversee the implementation of the health equity strategies, and what was the rationale for these?	How effective have the governance, monitoring, review, and accountability arrangements been, and what has needed to change?	How effective have the governance, monitoring, review, and accountability arrangements been, and what has needed to change?
	6	How do the health equity strategies' actions align with the ***Closing the Gap*** priority reforms?	How are the health equity strategies' actions contributing to the ***Closing the Gap*** priority reform?	How have the health equity strategies actions contributed to the ***Closing the Gap*** priority reform?
	7	How do the health equity strategies support and align with other state and national policy goals to improve the health and wellbeing of First Nations peoples?	How are the health equity strategies activities contributing to other national and state policy goals to improve the health and wellbeing of First Nations peoples?	How have the health equity strategies activities contributed to other national and state policy goals to improve the health and wellbeing of First Nations peoples?
Outcomes	**8**	Not applicable	To what extent are the health equity strategies achieving their expected outcomes?	To what extent did the health equity strategies achieve their expected outcomes?
	9	What unanticipated positive and negative outcomes resulted from developing and implementing health equity strategies for consumers, ATSICCHOs, services, the system, or other stakeholders?	What unanticipated positive and negative outcomes have resulted from implementing health equity strategies for consumers, ATSICCHOs, services, the system, or other stakeholders?	What unanticipated positive and negative outcomes resulted from implementing health equity strategies for consumers, ATSICCHOs, services, the system, or other stakeholders?
Impact	**10**	What are the activities under each priority area's roles and intended effects, and how will they work together to create the desired impacts?	How effective is the mix of activities under each priority area and activities in achieving health equity?	How effective was the mix of activities under each priority area and activities in achieving health equity?
	11	How have the health equity strategies embedded issues of intersectionality to address the needs of people such as the LGBTQISGBB+ community, people experiencing incarceration, people with disabilities, and young people in out-of-home care?	Have the health equity strategies been more effective in improving equity in service delivery, health, and wellbeing for some First Nations people than others?	Were the health equity strategies more effective in improving equity in service delivery, health, and wellbeing for some First Nations people than others?
Success	**12**	What have been the key facilitators and inhibitors to developing and implementing health equity strategies at the service, system, or sector level?	How have the services and system responded to facilitators and inhibitors to implementing health equity strategies at the service, system, or sector level identified in the previous evaluation, and what facilitators and inhibitors have emerged?	How have the services and system responded to facilitators and inhibitors to implementing health equity strategies at the service, system, or sector level identified in the previous evaluation, and what facilitators and inhibitors have emerged?
	13	What successes have already been realised, and how can they be leveraged to progress health equity reform?	What have been the most effective ways of bringing about change, and how can they be leveraged to progress health equity reform?	What were the most effective ways of bringing about change, and how can they be leveraged to progress health equity reform?
	14	How are the First Nations leadership reforms at the service and system level contributing to the health equity reform agenda, and what can be done to amplify their impact?	How are the First Nations leadership reforms at the service and system level contributing to implementing the health equity reform agenda, and what can be done to amplify their impact?	How did the First Nations leadership reforms at the service and system level contribute to implementing the health equity reform agenda, and what can be done to amplify their impact?
Sustain	**15**	What approaches to institutionalising and sustaining change have been incorporated into the health equity strategies or implementation plans?	What changes have been made at the service or system level to institutionalise and sustain learning and success from health equity reform?	What changes have been made at the service or system level to institutionalise and sustain learning and success from health equity reform?
Return on investment	**16**	How well can the design and implementation costs of the health equity strategies be captured? What benefits to health outcomes, service improvements, and broader social outcomes will be created by health equity strategies, and how can these be effectively measured?	How are the health equity strategies contributing to positive health outcomes, service improvements and broader social outcomes, and how do these benefits compare to the invested resources?	How have the health equity strategies contributed to positive health outcomes, service improvements and broader social outcomes, and how do these benefits compare to the invested resources?

Evaluative approach

The *Health Equity Strategies Monitoring and Evaluation Framework* uses four complementary underpinning approaches to maximise learning, adaptation, and transformation across the system.

These approaches are described below. Details of how they are applied are provided in Section 3.

Evaluative principles

The *Health Equity Strategies Monitoring and Evaluation Framework* principles reflect the values, cultural authority, and experiences of the First Nations' people heard through the co-design phase. The spirit and intent of the principles flow through all aspects of the *Health Equity Strategies Monitoring and Evaluation Framework*.

The individual principles hold no order of prioritisation. Rather, they come as a suite to guide the implementation of the evaluations.

The evaluative principles are:

- partnerships and trusting relationships
- including and respecting diverse voices, values, and knowledge
- sharing power
- community engagement and participation in decision-making
- cultural safety
- everyone's business (social justice and human rights approach)
- Aboriginal and Torres Strait Islander communities' control, leadership, and self-determination
- decolonising knowledge and practice
- evidence-based
- strengths-based narratives
- equitable and sensitive to context
- transformative (continuous quality improvement and learning)
- person-centred
- integrated and connected
- commitment and accountability.

Empowerment evaluation

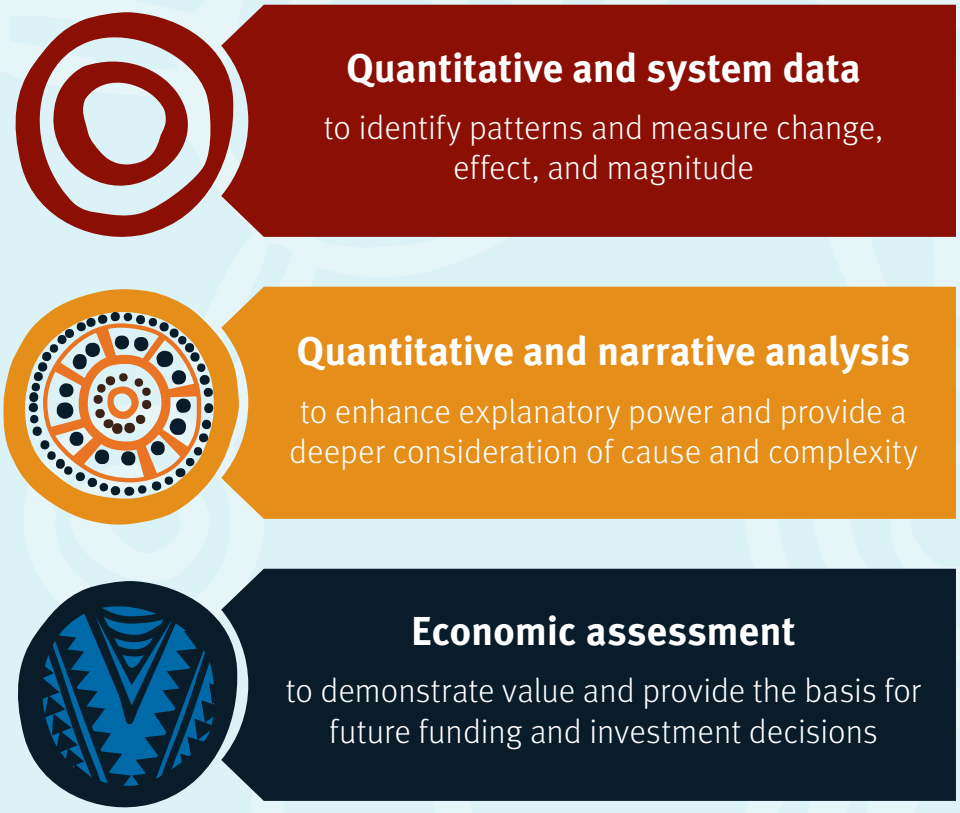
The *Health Equity Strategies Monitoring and Evaluation Framework* employs a systems-level empowerment evaluation approach[1]. Empowerment evaluation goes beyond standard evaluation by using two streams in its application.

- The first stream has a practical focus consistent with traditional formative evaluation and focuses on practical problem solving, programmatic improvements and outcomes.
- The second stream is the transformative element and supports liberation from conventional roles, structures, and ways of doing. This transformation is supported by the emphasis on challenging existing power structures, capacity building, and institutionalising change.

The *Health Equity Strategies Monitoring and Evaluation Framework* supports learning, accountability, and transformation, to ensure that decision-makers at all levels of the health system levels have evidence-based findings to identify what works, where improvement is needed, and what changes can best meet the health needs of First Nations peoples.

Three ways of knowing

Three ways of knowing will be used to address the evaluation questions, reduce methodological biases and meet the objectives of the *Health Equity Strategies Monitoring and Evaluation Framework*. The combination of approaches reflects best practice in evaluation and impact assessment.



Participatory action research

To support empowerment, the *Health Equity Strategies Monitoring and Evaluation Framework* is implemented using participatory action research (PAR) cycles of learning and action to:

- generate high-quality evidence
- strengthen capacity
- embed community voices
- foster collaborative, continuous learning
- facilitate service improvement
- support local decision making
- strengthen First Nations' leadership in evaluation.

The PAR approach will be implemented across the 16 HHS place-based settings as well as the system level to capture the different perspectives across the health system. This approach will maximise learning and expedite the translation of evaluative findings into policy and practice.

Operating the framework

Who will be involved?

The success of the health equity reform agenda depends on the representation, leadership and shared decision making with First Nations people and communities. The co-design and partnership approach to developing and implementing the health equity strategies was mandated because they are effective, best-practice principles for working with First Nations peoples.

Governance

The *Health Equity Strategies Monitoring and Evaluation Framework* was co-designed through the formation of a governance group consisting of the First Nations Health Office (Queensland Health), Queensland Aboriginal and Islander Health Council (QAIHC), Health and Wellbeing Queensland, and the First Nations health leads from each of the 16 HHSs. Their involvement ensured they had a strong voice on things of relevance and importance to them, finding potential solutions to issues determined by them, and setting an agenda to drive meaningful change for First Nations communities. The governance group comprised 95% First Nations representation. The governance group will be maintained to steer the implementation and ensure the translation of learning from the evaluations across the lifespan of the framework.

Independent evaluators

The *Health Equity Strategies Monitoring and Evaluation Framework* affirms the commitment made in *Making Tracks Together, Queensland's Aboriginal and Torres Strait Islander Health Equity Framework*, for the 3 evaluations to be conducted by independent external evaluators. The independent external evaluators will be selected to ensure the evaluation process upholds the *Health Equity Strategies Monitoring and Evaluation Framework*'s principles through First Nations leadership and employs methods that minimise non-Indigenous methodological bias.

Development Stakeholders

- First Nations Staff Members
- First Nations Health Consumers
- First Nations Community Members
- Traditional custodians/owners and native title holders in the service area

Implementation stakeholders

- Health and Wellbeing Queensland
- Chief First Nations Health Officer
- Queensland Aboriginal and Torres Strait Islander Health Council (QAIHC)

Service delivery stakeholders

- Aboriginal and Torres Strait Islander community-controlled health organisations (ATSICCHOs) in the service area
- Local primary healthcare organisations (including PHNs)

Consultation and engagement standards

The purpose of consultation and engagement practice standards is to ensure an equitable, respectful, consistent, and transparent process across the lifespan of the *Health Equity Strategies Monitoring and Evaluation Framework*. Consultation practices must be consistent with the principles of the *Health Equity Strategies Monitoring and Evaluation Framework* and reflect considerations of equity, safety, and voice.

Whilst there is no single organisation or group that can speak for First Nations people or communities, the inclusion of consumer voices is paramount to a credible and effective evaluation process. Evaluators must ensure that community representatives reflect a diversity of members and experiences. This requires the inclusion of community members beyond existing organisational advisory committees, board memberships, or sector leaders, and must include consumers with diverse social positions and intersectional identities that make them more at risk of inequitable health service experiences.

Term	Description
Shared decision-making	To work with the prescribed development stakeholders in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.
Collaboration	The act of working together with other people or organisations to create or achieve something.
Partnership	A formal arrangement and/or collaborative relationship between two or more parties that have agreed to work together, that is based on trust, equality, and mutual understanding, and focuses on the pursuit of common goals or interests.
Development stakeholder	Development stakeholders are prescribed in the *Hospital and Health Boards Regulation 2023*.
Prescribed stakeholders	Prescribed stakeholders are the persons prescribed by regulation in section 11(D) in the *Hospital and Health Boards Regulation 2023*.

From Making Tracks Together Queensland's Aboriginal and Torres Strait Islander Health Equity Framework

Successful implementation of the Health Equity Strategies Monitoring and Evaluation Framework will be driven by effective engagement and participation. The highly participatory and collaborative approaches draw success but are time-oriented and require adequate resourcing. The issue of resourcing strongly links back to the notion of equity and is underpinned by Reframing the Relationship.

Conducting the evaluations

Participatory action research

PAR is one of the underpinning evaluation approaches for the *Health Equity Strategies Monitoring and Evaluation Framework*. The approach aims to empower and transform processes, institutions, or communities consistent with Indigenous[2 3 4] and empowerment evaluation[1] approaches. It reflects the ways of working with community outlined in *Reframing the Relationship* and *The National Agreement on Closing the Gap* priority reforms.

Evaluation in the context of complex systems requires exploration of multiple perspectives, participation by the communities that are the intended beneficiaries of effective implementation, and those who plan, govern, manage, and deliver the health equity strategies. Participatory 'sense-making' processes are a way to incorporate elements of context, wider systems influences and health system dynamics[5]. A PAR approach is emergent and embedded in transformation leveraging highly participatory evaluation practices to maximise system change and learning across time. The value of participatory and collaborative processes with First Nations peoples is well-tested and upheld as best practice. It generates high-quality evidence, strengthens partnerships and First Nations leadership in evaluation, strengthens capacity, fosters collaborative and continuous learning, and facilitates service improvement and local decision-making in an all-teach-all-learn approach[6].

The PAR approach will be implemented across the 16 HHS place-based settings to capture the different perspectives across the health system. Participants will include the prescribed stakeholders to uphold the principles of *Making Tracks Together* and *Reframing the Relationship*. Implementing the evaluation requires assessments made using systematic improvement and transparent processes for combining qualitative and quantitative data with the relevant values for drawing robust, culturally valid, credible conclusions.

Evaluation participants will include:

- Independent First Nations Evaluator to co-design and conduct the evaluations, providing transparency of the process and supporting the capacity building and empowerment elements of the evaluations.
- HHS staff, including the executive teams, boards, and relevant staff necessary to contribute evidence, participate in interpretation and sense making, provide input to evaluative recommendations, and support learning and adaptation.
- Queensland Health staff, including the First Nations Health Office, data custodians, policy and governance staff to contribute evidence, participate in interpretation and sense making, provide input to evaluative recommendations, and support learning and adaptation.
- Prescribed stakeholders, as identified by the legislation, to contribute evidence, participate in interpretation and sense making, provide input to evaluative recommendations, and support learning and adaptation.
- Health consumers, including community members beyond existing organisational advisory committees, board memberships, or sector leaders, and must include consumers with diverse social positions and intersectional identities that make them more at risk of inequitable health service experiences.

3 ways of knowing: A composite assessment structure

The *Health Equity Strategies Monitoring and Evaluation Framework* is underpinned by a modified application of the Framework to Assess the Impact of Translational health research methodology[7] [8] (FAIT). FAIT was developed to assess and optimise research translation in the health sector and has been successfully applied to evaluate health policy and programs[9] [10]. The value of FAIT is that it provides a line of sight from need to impact and through applying three complimentary methods an explanation and measurement of change.

FAIT is a composite methodology that integrates three validated methods to assess impact: adapted payback, narratives of translation, and economic analysis. This combination of methods provides a robust and multidimensional approach to assessing the impact of the health equity strategies, pathways to impact, and return on the implementation costs whilst facilitating learning, translation, and adaptation across the system.
This approach is ideal for the evaluation goals, principles, and processes.

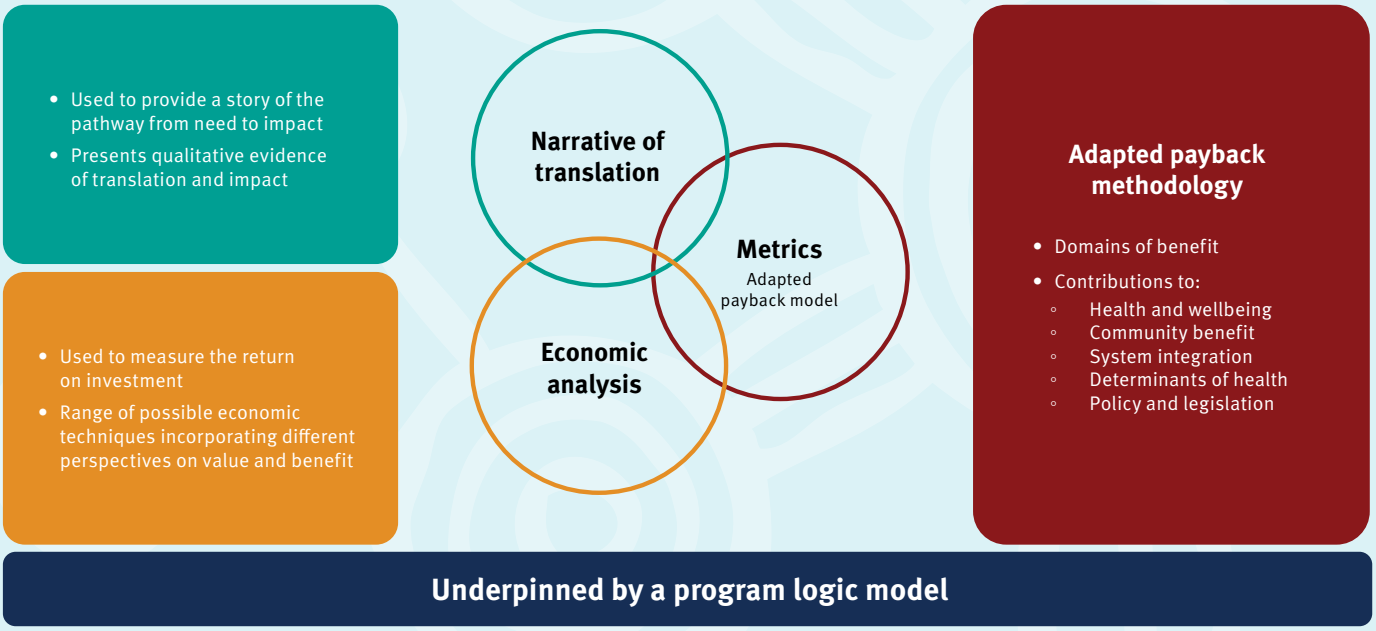


Diagram adapted from: Ramanathan, S. et al (2022). https://doi.org/10.1186/s12960-022-00781-6

Quantitative data (metrics)

The modified FAIT design leverages existing performance monitoring and reporting data and processes to ensure relevance, improve coherence, and reduce institutional burden. The metrics referred to in FAIT modify the methods used in the Payback Framework[11]. The Payback Framework is one of the most common methods employed for measuring impact. The method is based on the identification of domains of benefit relevant to the context and evaluation questions. Examples of domains of benefit include:

Domains of benefit

Direct effects to:

- health gains (including wellbeing[12])
- patient experience and outcomes
- service quality and efficiencies
- workforce.

Flow-on effects to:

- education, employment
- lifecourse trajectories
- intergenerational wellbeing
- quality of life.

Appropriate process, outcome and impact metrics will be identified to populate the domains of benefit as part of the co-design process with prescribed stakeholders and informed by a Data Feasibility Assessment. Metrics are also structured to support economic assessment.

There are stark differences across the geographical, socio-economic, and organisational spaces of the HHSs and the communities they serve. Alongside those diverse contexts and needs are services and systems that respond to place.

For these reasons, between site quantitative comparisons are not appropriate nor should they be undertaken.

Narratives of translation

For evaluation to effectively assess programme objectives against higher-level goals, including intended and unintended results, deal with complex issues, and answer causal questions, it must look beyond quantitative analysis.

Qualitative data can be captured from the analysis of existing documents and reviews. Data generation must minimise non-Indigenous methodological bias, by using methods such as yarning. Yarning supports cultural safety and generates rich descriptions through interaction to create deeper insights[13].

Narratives of translation provide a powerful opportunity to make meaning from the metrics collaboratively. Case studies enable quantitative findings to be placed in context. They are an opportunity to explain variances in costs, outputs and impacts and explore the transferability or scalability of activities across the system. Case studies are stories of significance that provide richer insights to complement the quantified metrics and economic analysis. The narratives capture and draw meaning from the experiences of health equity reform, allow a deeper exploration of how transformation and impact were created, and evidence impacts that cannot be captured through the other methods.

For each of the *Health Equity Strategies Monitoring and Evaluation Framework's* three system level evaluations, qualitative data will be captured and generated across sites to delve more deeply into understanding what works, for whom, through which mechanisms of change, and with what consequences. Qualitative analysis must also minimise non-Indigenous methodological bias by employing relational and systems based methods that go beyond simple description or classification to consider the broader situation of inquiry and manage complexity[14] [15]. The analysis must adopt a de-colonising and phronetic approach[16], by considering issues such as 'what are the conditions in which this is enabled/enacted?', 'what are the mechanisms of power in this situation?' and 'how does this manifest and under what conditions, and for whom?'

Economic analysis

The economic assessment estimates the return on investment for the health equity strategies, considering the implementation costs against the outcomes and impacts they have created. Robust economic evaluation is required to demonstrate value for money and provide the basis for future funding and investment decisions[17]. Economic evaluation, however, is not an exact science. Various assumptions are required, and decisions must be made when data is limited and/or incomplete to balance the need to capture significant effects whilst ensuring feasibility[18].

Economic evaluation within a health care system where the government bears the primary costs of health care delivery traditionally focuses only on the health care service perspectives and limited consumer health outcomes. Alternatively, a societal perspective can include broader costs and impacts across the sector and community. A societal perspective can include job creation, health care costs, consumer, and stakeholder costs, and impacts on non-health sectors (such as education, police/courts, production gains or losses in the broader economy). Given the inclusion of the social determinants of health as a key priority area in the health equity strategies, a societal perspective such as social return on investment (SROI) is more appropriate for the *Health Equity Strategies Monitoring and Evaluation Framework*[7 19].

SROI is a principles-based approach for understanding and measuring the broader concept of 'value' and incorporates social, environmental, and economic impacts. It involves working with those affected by the organisation/activity, and, calculating and understanding its worth to them. SROI extends the traditional monetary ROI analysis to help organisations understand and quantify the social value they create as defined by First Nations peoples. The value can include quantifying individual health and well-being improvements, service efficiencies, and the community's social, economic, and cultural benefits. The concept of SROI strongly emphasises stakeholder engagement and participation in defining value and its measurement. Participation ensures that the evaluations better suit the cultural needs of First Nations peoples and adhere to the principles of Indigenous data sovereignty.

Principles of SROI[19]:

- involve stakeholders
- understand what changes
- value the things that matter
- only include what is material
- do not over-claim
- be transparent
- verify the result.

Six steps of SROI[19]:

1. establishing scope and involving stakeholders
2. mapping outcomes
3. evidencing and valuing outcomes
4. establishing impact
5. calculating the SROI and sensitivity analysis
6. using and embedding findings.

Data assessment and management

Health systems collect, generate and report data daily, creating an illusion of a rich, comprehensive, and accessible resource that can be used to answer evaluative questions. In reality, whilst health systems generate a lot of valuable data, there are problems when we want to use it for other purposes such as evaluation. These problems include the completeness, accuracy, timeliness, and appropriateness of the data for the application. Accessing data can also require long lead times to ensure ethical and regulatory requirements are met and can be resource intensive. However, routinely collected and system-created data sets can provide important insights and evidence to realise an evaluation's goals, and support system learning and adaptation.

To ensure the fitness and quality of quantitative data, reduce risks to evaluation timelines, and adhere to the evaluative principles, a pre-evaluation Data Feasibility Assessment (DFA) should be undertaken. The DFA will systematically identify and determine which routinely collected and standalone data sets are suitable for the evaluations and what processes, timeframes, and resources are required to access them.

Routinely collected data sets have inherent limitations of not being designed for the purpose they are being used, are selective in relation to personal characteristics, can be incomplete, illegible, or missing, vary in diagnostic quality, or have poorly defined denominators. These datasets have also been identified as problematic because the measures are reductionist, de-contextualised, and deficit focus[20 21].

An initial DFA will be undertaken either as a pre-evaluative assessment or as part of the first evaluation. If undertaken as part of the first evaluation it will incorporate the data specification (indicator identification and mapping), extraction protocols and analysis planning. The DFA will be revisited prior to each evaluation to reflect a maturity model enabling the analysis of existing data collections in initial evaluation touch points and to leverage planned new collections and improvements in data quality to undertake a more comprehensive analysis over the life of the *Health Equity Strategies Monitoring and Evaluation Framework*.

The Data Feasibility Assessment will:

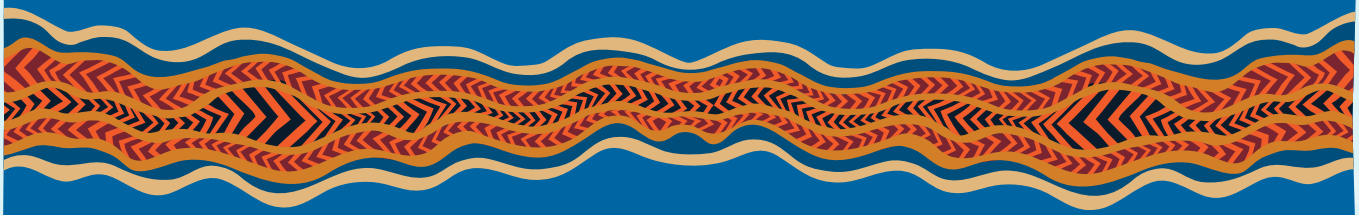
1. Identify routinely collected and standalone data sets from existing performance monitoring and reporting processes that may be useful in answering the evaluation questions or providing contextual information that may be used to support analysis.
2. Establish processes for gaining access to these data sets for the purpose of the evaluation, including ethical requirements and costs.
3. Assess the fitness-for-purpose of each identified data set, including relevance, timeliness, completeness, and accuracy (particularly concerning the effects of voluntary identification, collection methodologies, denominator data sources and data cleaning).
4. Assess the consistency and comparability of the indicators between HHSs, the appropriateness of the indicator for its intended use; and the consistency of data sets and indicators with the principles of Indigenous Data Sovereignty.
5. Provide a robust basis for metric identification and selection; guide the generation of qualitative data to address gaps in understanding; and inform future data improvements.

Data sovereignty

Implementation of the *Health Equity Strategies Monitoring and Evaluation Framework* requires that all activities be conducted in accordance with the principles of Indigenous data governance and sovereignty, as much as feasibly possible.

The principles, as advocated by the Lowitja Institute[22], will guide the evaluations including data management:

- reflect Aboriginal and Torres Strait Islander interests, values, and priorities, including cultural ways of knowing, being and doing
- be collected with free, prior, and informed consent, including respect for confidentiality
- be returned in an easily understood and meaningful way
- be used to advance self-determination and development
- be accessible, appropriate, and meet Aboriginal and Torres Strait Islander needs
- be stored securely
- be interpreted by Aboriginal and Torres Strait Islander experts, ensuring it reflects Aboriginal and Torres Strait Islander lived experiences and perspectives
- only be used how Aboriginal and Torres Strait Islander people, communities and organisations agree.



Applying the principles

The evaluation questions should be applied using the principles as analytic prompts to support a de-colonising and phronetic approach[16] through the consideration of issues such as power, voice, context, accountability, and cultural safety. These considerations should extend beyond the focus of inquiry to the conduct of the evaluation itself.

Partnerships and trusting relationships
Commitment to genuine partnerships and fostering relationships with First Nations people in Queensland vertically and horizontally across the health system must be considered in the first tranche of the evaluation.

Sharing power
The evaluation must focus on promoting and respecting the self-determination, ownership and control of First Nations people in Queensland. This includes, but is not limited to, shared priority-setting, shared decision-making, determination of benefits and sharing resources across the health system.

Community engagement and participation in decision-making
Sharing power as in the previous point, must extend to all First Nations people in Queensland.

Including and respecting diverse voices, values, and knowledge
The evaluation must prioritise the inclusion of diverse perspectives, experiences, needs and aspirations in the evaluation's engagements and voice. It should consider the intersections of ethnicity, gender, class, sexuality, ability, and many other identities.

Cultural respect and safety
In the evaluation, there must be central recognition, protection and advancement of the inherent rights, cultures, and traditions of First Nations people in Queensland.

Everyone's business (social justice and human rights approach)
The evaluation must prioritise participation and input from all stakeholders with responsibility or expertise in setting policy for and operationalising equity. The delivery of equity in service delivery is everyone's responsibility.

Aboriginal and Torres Strait Islander communities' control, leadership, and self-determination
Ensuring First Nation's inclusion and leadership at all levels of the evaluation. In practice, this includes negotiating consent, accountabilities, resources, governance, and decision-making.

Decolonising knowledge and practice
Centring First Nations' knowledge and ways of being and doing must be a central focus of the evaluation.

Evidence-based
The evaluation should consider how strategies and practices are embedded in the best relevant research evidence — what works or promising practice for First Nations people in Queensland — in accordance with need and context. Research evidence should be integrated with clinical expertise and person-centred values and circumstances.

Integrated and connected
Care is holistic and integrated across the health system. The evaluation must centre on First Nations people in Queensland's needs and aspirations for their health and wellbeing and for service delivery.

Strengths-based narratives
The evaluation must approach and report strength-based narratives. While quantitative data tells one story, narratives about people's experiences and aspirations are also vital. Ethical storylines that return narratives about First Nations people in Queensland to a position of strength that grounds stories in how First Nations people in Queensland see themselves and bring their resilience and aspirations to the fore is critical. These narratives celebrate the success, strength, resilience and capabilities of First Nations people in Queensland and the innovations of health services in meeting their needs.

Equitable and sensitive to context
The evaluation must consider the significance of place-based service and needs. Good quality care for First Nations people in Queensland must be accessible, according to needs; in the right way, at the right time regardless of place. Care must be equitable, accessible, and culturally safe for all First Nations people in Queensland.

Transformative (continuous quality improvement and learning)
Change efforts must embed continuous quality improvement processes to produce a solid evidence base for service improvement. The evaluation must approach the work and analyse and interpret findings with a transformative lens.

Person-centred
Care is person-centred, compassionate, respectful and in accordance with the unique cultural needs of First Nations people in Queensland. This approach is key to what service delivery means for First Nations people in Queensland and is the benchmark for 'good' in the evaluation.

Commitment and accountability
The evaluation must recognise the essential rights of First Nations people in Queensland to equitable health and commit to the principles outlined. There must also be accountability to ensure that projects are implemented ethically and responsibly. This means creating a shared vision of how the latter looks with all stakeholders, setting clear goals and expectations, engaging in continuous dialogue, feedback and sense-making in transformation efforts, and leaving a positive impact through the evaluation.

Addressing the evaluation questions

The evaluation questions have been designed to meet the *Health Equity Strategies Monitoring and Evaluation Framework* objectives by adopting a de-colonising stance when addressing them. To support learning and accountability, evaluators must consider each question with a critical stance of looking backward (what has happened and why) then looking forward (what needs to happen now).

The following guide for each of the evaluation questions supports evaluation fidelity by providing:

- differences in its application between evaluations (implementation, mid-term impact and outcome)
- clarification of the purpose and logic for each question
- clarification of key concepts not already defined elsewhere in this document
- analytic considerations across the system levels (service, system) or place[23]
- potential data sources for the composite assessment structure.

Evaluation question 1		
Cycle adaptation	1	What contextual factors influenced the design of the health equity strategies, and how will the activities under each priority area respond to them to achieve equity in service delivery and health outcomes?
	2	What contextual changes have impacted the health equity reform agenda, and how have the activities under each priority area responded to them to achieve equity in service delivery and health outcomes?
	3	What contextual changes have impacted the health equity reform agenda, and how have the activities under each priority area adapted to them to ensure equity in service delivery and health outcomes?

Purpose

There are stark differences across the geographical and socio-economic spaces of HHSs and the communities they serve. These differences are reflected in both the demands on services (health needs) and their access to resources to provide services (workforce, infrastructure, equipment).

This question ensures that the evaluations understand and incorporate the influence of contextual differences for each of the 16 HHSs on the design and implementation of their health equity strategies. Given the dynamic nature the environments services operate in, this must be considered for each of the evaluations.

Consider	
At the HHS level	• organisational demands (health needs) • access to resources • absorptive capacity, agility, and resilience • inter-organisational networks and relationships.
At the system level	• policy drivers and priorities • system responsiveness and resourcing • incentives and mandates • regulatory frameworks or external accreditation systems • inter-organisational networks and relationships.
Place based	• local health needs and priorities (including climate, cultural, and socio-economic drivers) • system coordination and integration • number, type, and capacity of local health services • inter-organisational networks and relationships.
Composite assessment	
Metrics	• HHS Health Needs Assessments • system data on demand and resourcing factors • DFA to consider value and feasibility of measuring change in the organisational context over future cycles.
Narrative	• consultation (key informant interviews, stakeholder meetings, community yarns) • desktop research (document and archival review).
Social return on investment	• changes in health need profiles • changes in resource availability and access.

Evaluation question 2

Cycle adaptation	
1	How did institutional understanding and commitment to addressing health equity influence the design and implementation of health equity strategies?
2	How has institutional understanding and commitment to addressing health equity changed, and with what effect?
3	How has institutional understanding and commitment to addressing health equity changed, and with what effect?

Purpose

Just as there are contextual differences between the places HHSs serve, there are significant differences in their organisational spaces. These differences are reflected in the organisations' history and relationship with First Nations consumers and communities, level of institutional racism, cultural safety, organisational culture, structure processes, and service delivery.

This question ensures that the evaluations understand and incorporate the influence of institutional differences for each of the 16 HHSs on the design and implementation of their health equity strategies. Given the *Health Equity Strategies Monitoring and Evaluation Framework*'s objective of supporting learning and transformation, this must be considered for each of the evaluations.

Consider

At the HHS level	• organisational priorities • leadership support (formal and informal) • experience of innovation and change • cultural safety • absorptive capacity, agility, and resilience • inter-organisational networks and relationships • community engagement and participation.
At the system level	• policy drivers and priorities • system responsiveness and resourcing • incentives and mandates • regulatory frameworks or external accreditation systems • inter-organisational networks and relationships.

Composite assessment

Metrics	• DFA to consider value and feasibility of measuring change in the organisational context over future cycles • DFA to assess and monitor development of CTG PR indicators • caution should be exercised in use of crude measures of expenditure or service delivery based on consumer's Aboriginal and/or Torres Strait Islander identity.
Narrative	• consultation (key informant interviews, stakeholder meetings, community yarns) • desktop research (document and archival review), including a qualitative consideration of HHS assessments in *Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services*.
Social return on investment	• unsuited for economic analysis without robust metric.

Evaluation question 3

Cycle adaptation	
1	How were the activities under each priority area identified and decided by the co-design group, and with what effect? To what extent were there opportunities for innovation or influence by stakeholders? What influence did existing programs, initiatives, or alliances to improve health outcomes for First Nations peoples have on the development of health equity strategies?
2 3	The review and adaptation of strategies in the later tranches are addressed in *evaluation question 5*.

Purpose

Health equity reform builds on a long history on a long history of targeted health programs and requires the transformation of the health system and the way healthcare is delivered, to address institutional racism and deliver care based on what First Nations people need to attain their full health potential. Consumer consultations[24] highlighted concerns that health equity reform was simply a new name for business as usual with no real structural change.

This question ensures the evaluation assesses the process and influences on the design of the health equity strategies, particularly the priority activities. In addressing this question, each evaluation must consider not only the influence of existing initiatives and alliances to improve First Nations Health, but whether the strategies responded to stakeholder and consumer input to create structural change.

Consider

At the HHS level	• existing organisational priorities and programs • leadership support (formal and informal) • experience of innovation and change • cultural safety • absorptive capacity, agility, and resilience • inter-organisational networks and relationships with stakeholders • community engagement and participation.
At the system level	• policy drivers and priorities • system responsiveness and resourcing • incentives and mandates • regulatory frameworks or external accreditation systems • inter-organisational networks and relationships.
Place based	• existing initiatives and programs • system coordination and integration • number, type, and capacity of local health services • inter-organisational networks and relationships.

Composite assessment

Metrics	• caution should be exercised in use of crude measures of expenditure or service delivery based on consumer's Aboriginal and / or Torres Strait Islander identity.
Narrative	• consultation (key informant interviews, stakeholder meetings, community yarns) • desktop research (document and archival review).
Social return on investment	• unsuited for economic analysis without robust metric.

Evaluation question 4		
Cycle adaptation	1	How did the health equity strategies co-design processes uphold the legislative requirements, the principles of *Making Tracks Together*, and the Queensland Government's commitment to reframing the relationship with First Nations peoples? What effect did this have on decision-making and implementation?
	2	How have the health equity strategies upheld the legislative requirements, the principles of *Making Tracks Together*, and the Queensland Government's commitment to reframing the relationship with First Nations peoples, and to what effect?
	3	How have the health equity strategies upheld the legislative requirements, principles of *Making Tracks Together*, and the Queensland Government's commitment to reframing the relationship with First Nations peoples, and to what effect?

Purpose
Legislation is viewed as the most powerful lever for structural change. This question ensures the evaluation considers the difference in influence between legislated and relational approaches to transformation, given the potential consequences of non-compliance.

Consider	
At the HHS level	• organisational priorities • leadership support (formal and informal) • local governance, performance, and accountability mechanisms • inter-organisational networks, relationships, and accountability mechanisms • community engagement and participation.
At the system level	• purpose and influence of legislation • policy drivers and priorities • system level governance, performance, and accountability mechanisms • incentives and mandates • inter-organisational networks, relationships, and accountability mechanisms.
Place based	• number, type, and capacity of local health services • inclusion of diverse voices, values, and knowledges • First Nations leadership and self determination • inter-organisational networks, relationships, and accountability mechanisms.

Composite assessment	
Metrics	• DFA to consider if any appropriate metrics are available, under development or worth developing.
Narrative	• consultation (key informant interviews, stakeholder meetings, community yarns) • desktop research (document and archival review).
Social return on investment	• unsuited for economic analysis without robust metric.

Evaluation question 5		
Cycle adaptation	1	What governance, monitoring, and accountability arrangements were adopted to oversee the implementation of the health equity strategies, and what was the rationale for these?
	2	How effective have the governance, monitoring, review, and accountability arrangements been, and what has needed to change?
	3	How effective have the governance, monitoring, review, and accountability arrangements been, and what has needed to change?

Purpose

Good governance and accountability underpin the way governments need to work with First Nations peoples and communities. Transparency and accountability are necessary to identify and address institutional racism. This question ensures the evaluations consider the effect of governance, monitoring, and accountability arrangements.

Consider	
At the HHS level	• organisational priorities • leadership support (formal and informal) • local governance, performance, and accountability mechanisms • inter-organisational networks, relationships, and accountability mechanisms • community engagement and participation.
At the system level	• purpose and influence of legislation • policy drivers and priorities • system level governance, performance, and accountability mechanisms • incentives and mandates • inter-organisational networks, relationships, and accountability mechanisms.
Place based	• number, type, and capacity of local health services • inclusion of diverse voices, values and knowledges • First Nations leadership and self determination • inter-organisational networks, relationships, and accountability mechanisms.
Composite assessment	
Metrics	• DFA to consider local and system level monitoring and reporting frameworks.
Narrative	• consultation (key informant interviews, stakeholder meetings, community yarns) • desktop research (document and archival review).
Social return on investment	• unsuited for economic analysis without robust metric.

Evaluation question 6

Cycle adaptation		
	1	How do the health equity strategies' actions align with the *Closing the Gap* priority reforms?
	2	How are the health equity strategies' actions contributing to the *Closing the Gap* priority reform?
	3	How have the health equity Strategies' actions contributed to the *Closing the Gap* priority reform?

Purpose

The priority reforms are central to *The National Agreement on Closing the Gap* and directly informed by Aboriginal and Torres Strait Islander people. The reforms outline the structural changes governments need to make in the way they work with Aboriginal and Torres Strait Islander people to close the gap. health equity strategies must be consistent with the transformative elements of these priority reforms if they are to be effective in achieving healthy parity for First Nations people in Queensland.

This question provides an opportunity to consider the alignment of the mechanisms of change in the health equity strategies with the priority reforms to assess their likelihood of success, and the effects of coherence or inconsistency as well as identify potential duplication of effort. It contributes to understanding the barriers and facilitators of success.

Consider

Priority reform 1	**How the strategies incorporate:** • accountable and representative partnerships • formal agreements • shared decision making.
Priority reform 2	**How the strategies contribute to building the community controlled sector through:** • capacity building and investment (ATSICCHOs and peak body) • supporting the growth and retention of the Aboriginal and Torres Strait Islander workforce in the community controlled sector • dedicated, reliable and consistent funding to provide services required by communities. **At a system level consider:** • what influence the health equity reform agenda is having on the Peak Body.
Priority reform 3	**How the strategies:** • identify and eliminate racism • embed and practice meaningful cultural safety • deliver services in partnership with Aboriginal and Torres Strait Islander organisations, communities and people • increase accountability through transparent funding allocations • support Aboriginal and Torres Strait Islander cultures • improve engagement with Aboriginal and Torres Strait Islander people.

Evaluation question 6 continued...	
Consider	
Priority reform 4	**How the strategies:** • incorporate partnerships to improve collection, access, management, and use of data for shared decision making • provide communities and organisations with access to the same data and information they use to make decisions • make data more transparent by telling Aboriginal and Torres Strait Islander people what data the HHS has and how it can be accessed • build capacity of Aboriginal and Torres Strait Islander organisations and communities to collect and use data.
Composite assessment	
Metrics	• DFA to assess and monitor the development of *The National Agreement on Closing the Gap* priority reform indicators • system data on funding, commissioning, or transfer of service delivery to ATSICCHOs and contribution to the growth and retention of the Aboriginal and Torres Strait Islander workforce in the community controlled sector • contribution of strategy actions to changes in scores against the *Bukal Institutional Racism Matrix* or other organisational measures of racism.
Narrative	• consultation (key informant interviews, stakeholder meetings, community yarns) • desktop research (document and archival review), including mapping of strategy actions against transformative elements.
Social return on investment	• consideration of the health and social benefits from changes identified from metric.

Evaluation question 7		
Cycle adaptation	1	How do the health equity strategies support and align with other state and national policy goals to improve the health and wellbeing of First Nations peoples?
	2	How are the health equity strategies activities contributing to other national and state policy goals to improve the health and wellbeing of First Nations peoples?
	3	How have the health equity strategies activities contributed to other national and state policy goals to improve the health and wellbeing of First Nations peoples?

Purpose

This question provides an opportunity to consider the alignment of the health equity strategies with other policy initiatives to assess the effects of coherence or inconsistency as well as identify potential duplication of effort. It contributes to understanding the barriers and facilitators of success.

Consider	
At the HHS level	• organisational priorities and demands • leadership support (formal and informal) • absorptive capacity, agility, and resilience • inter-organisational networks and relationships with stakeholders.
At the system level	• policy drivers and priorities • system responsiveness and resourcing • incentives and mandates • regulatory frameworks or external accreditation systems • inter-organisational networks and relationships.
Place based	• number, type, and capacity of local health and other relevant services • First Nations leadership and self determination • inter-organisational networks, relationships, and accountability mechanisms.
Composite assessment	
Metrics	• DFA to consider if any appropriate metrics are available, under development or worth developing.
Narrative	• consultation (key informant interviews, stakeholder meetings, community yarns) • desktop research (document and archival review).
Social return on investment	• unsuited for economic analysis without robust metric.

Evaluation question 8

Cycle adaptation		
	1	The development of the initial health equity strategy and Implementation plan are assessed in evaluation question 3.
	2	To what extent are the health equity strategies achieving their expected outcomes?
	3	To what extent did the health equity strategies achieve their expected outcomes?

Purpose

In the midterm and outcome evaluations, this question assesses the extent to which the intended outcomes of the health equity strategies have been realised. In addressing this question, the evaluations must move beyond crude quantification of performance to consider what works, for whom, through which mechanisms of change, and with what consequences.

Consider

At the HHS level	• organisational priorities • leadership support (formal and informal) • organisational demands (health needs) • access to resources • absorptive capacity, agility, and resilience • local governance, performance, and accountability mechanisms • inter-organisational networks, relationships, and accountability mechanisms • community engagement and participation.
At the system level	• policy drivers and priorities • system level resourcing, governance, performance, and accountability mechanisms • incentives and mandates • inter-organisational networks, relationships, and accountability mechanisms.
Place based	• number, type, and capacity of local health services • differences and changes in local context • inclusion of diverse voices, values and knowledges • First Nations leadership and self determination • inter-organisational networks, relationships, and accountability mechanisms.

Composite assessment

Metrics	• DFA to consider local and system level monitoring and reporting frameworks • DFA to assess the outcome indicators in the health equity strategies.
Narrative	• consultation (key informant interviews, stakeholder meetings, community yarns) • desktop research (document and archival review).
Social return on investment	• consideration of the health and social benefits from changes identified from metric.

Evaluation question 9		
Cycle adaptation	1	What unanticipated positive and negative outcomes resulted from developing and implementing health equity strategies for consumers, ATSICCHOs, services, the system, or other stakeholders?
	2	What unanticipated positive and negative outcomes have resulted from implementing health equity strategies for consumers, ATSICCHOs, services, the system, or other stakeholders?
	3	What unanticipated positive and negative outcomes resulted from implementing health equity strategies for consumers, ATSICCHOs, services, the system, or other stakeholders?

Purpose

Any changes in a system can create unanticipated outcomes that can be positive or negative. These outcomes may affect the organisation making the changes, their partners, consumers, other stakeholders, or the broader system. This question ensures the evaluation captures unintended outcomes to support learning and accountability. The identification of positive outcomes provides opportunities for transfer or scale, whilst the identification of negative outcomes provides an opportunity to remedy or adapt activities.

Consider	
At the HHS level	• organisational priorities • leadership support (formal and informal) • organisational demands (health needs) • access to resources • absorptive capacity, agility, and resilience • local governance, performance, and accountability mechanisms • inter-organisational networks, relationships, and accountability mechanisms • community engagement and participation.
At the system level	• policy drivers and priorities • system level resourcing, governance, performance, and accountability mechanisms • incentives and mandates • inter-organisational networks, relationships, and accountability mechanisms.
Place based	• number, type, and capacity of local health services • differences and changes in local context • inclusion of diverse voices, values and knowledges • First Nations leadership and self determination • inter-organisational networks, relationships, and accountability mechanisms.
Composite assessment	
Metrics	• DFA to consider local and system level monitoring and reporting frameworks • consideration of appropriate metrics from outcomes identified by the evaluation.
Narrative	• consultation (key informant interviews, stakeholder meetings, community yarns) • desktop research (document and archival review).
Social return on investment	• consideration of the health and social benefits (or loss) from changes identified from metric.

Evaluation question 10		
Cycle adaptation	1	What are the activities under each priority area's roles and intended effects, and how will they work together to create the desired impacts?
	2	How effective is the mix of activities under each priority area and activities in achieving health equity?
	3	How effective was the mix of activities under each priority area and activities in achieving health equity?

Purpose

Systems and implementation theory highlight the importance of considering the effect of interaction, alignment and coherence of interventions designed to create change. This question provides an opportunity to consider these aspects of the strategies through a complexity lens.

Consider	
At the HHS level	• organisational priorities • leadership support (formal and informal) • organisational demands (health needs) • access to resources • absorptive capacity, agility, and resilience • local governance, performance, and accountability mechanisms • inter-organisational networks, relationships, and accountability mechanisms • community engagement and participation.
At the system level	• policy drivers and priorities • system level resourcing, governance, performance, and accountability mechanisms • incentives and mandates • inter-organisational networks, relationships, and accountability mechanisms.
Place based	• differences and changes in local context • inclusion of diverse voices, values, and knowledges • First Nations leadership and self determination • inter-organisational networks, relationships, and accountability mechanisms.
Composite assessment	
Metrics	• consideration of potential metrics if identified by the qualitative analysis.
Narrative	• consultation (key informant interviews, stakeholder meetings, community yarns) • desktop research (document and archival review).
Social return on investment	• consideration of the health and social benefits from changes if they can be linked to a suitable metric.

Evaluation question 11

Cycle adaptation	
1	How have the health equity strategies embedded issues of intersectionality to address the needs of people such as the LGBTQISGBB+ community, people experiencing incarceration, people with disabilities, and young people in out-of-home care?
2	Have the health equity strategies been more effective in improving equity in service delivery, health, and wellbeing for some First Nations people than others?
3	Were the health equity strategies more effective in improving equity in service delivery, health, and wellbeing for some First Nations people than others?

Purpose

Fundamental to the evaluation of equity reform is consideration of the influence of intersectional identities and experiences of multiple forms of discrimination and marginalisation that impact First Nations peoples' access to and experiences of healthcare. This question ensures the evaluations consider the impact of the health equity strategies in addressing what all First Nations people need to attain their full health potential.

Consider

At the HHS level	• organisational priorities • leadership support (formal and informal) • organisational demands (health needs) • access to resources • absorptive capacity, agility, and resilience • local governance, performance, and accountability mechanisms • inter-organisational networks, relationships, and accountability mechanisms • community engagement and participation.
At the system level	• policy drivers and priorities • system level resourcing, governance, performance, and accountability mechanisms • incentives and mandates • inter-organisational networks, relationships, and accountability mechanisms.
Place based	• inclusion of diverse voices, values, and knowledges • differences and changes in local context • First Nations leadership and self determination • inter-organisational networks, relationships, and accountability mechanisms.

Composite Assessment

Metrics	• consideration of potential metrics if identified by the qualitative analysis • caution must be exercised when considering the effect of disaggregating small populations and the requirement to adhere to ethical requirements.
Narrative	• consultation (key informant interviews, stakeholder meetings, community yarns) • desktop research (document and archival review).
Social return on investment	• consideration of the health and social benefits (or loss) from changes if they can be linked to a suitable metric.

Evaluation question 12		
Cycle adaptation	1	What have been the key facilitators and inhibitors to developing and implementing health equity strategies at the service, system, or sector level?
	2	How have the services and system responded to facilitators and inhibitors to implementing health equity strategies at the service, system, or sector level identified in the previous evaluation, and what facilitators and inhibitors have emerged?
	3	How have the services and system responded to facilitators and inhibitors to implementing health equity strategies at the service, system, or sector level identified in the previous evaluation, and what facilitators and inhibitors have emerged?

Purpose

This question has two functions. It provides a focused examination of the barriers and enablers to transformation through the implementation of the strategies. Consistent with Learning Health Systems[25], it also ensures an assessment of barriers and enablers to recommended changes identified from the evaluation findings.

Consider	
At the HHS level	• organisational priorities • leadership support (formal and informal) • organisational demands (health needs) • access to resources • absorptive capacity, agility, and resilience • local governance, performance, and accountability mechanisms • inter-organisational networks, relationships, and accountability mechanisms • community engagement and participation.
At the system level	• policy drivers and priorities • system level resourcing, governance, performance, and accountability mechanisms • incentives and mandates • inter-organisational networks, relationships, and accountability mechanisms.
Place based	• differences and changes in local context • inclusion of diverse voices, values, and knowledges • First Nations leadership and self determination • inter-organisational networks, relationships, and accountability mechanisms.
Composite assessment	
Metrics	• consideration of potential metrics if identified by the qualitative analysis.
Narrative	• consultation (key informant interviews, stakeholder meetings, community yarns) • desktop research (document and archival review).
Social return on investment	• consideration of the health and social benefits from changes if they can be linked to a suitable metric.

Evaluation question 13		
Cycle adaptation	1	What successes have already been realised, and how can they be leveraged to progress health equity reform?
	2	What have been the most effective ways of bringing about change, and how can they be leveraged to progress health equity reform?
	3	What were the most effective ways of bringing about change, and how can they be leveraged to progress health equity reform?

Purpose

Consistent with a strengths-based approach to evaluation, Learning Health Systems[25], and the ***Health Equity Strategies Monitoring and Evaluation Framework's*** object to support transfer and scaling up of best practice, this question ensures the evaluation includes a focussed examination of success factors across the system, and identifies what can be done to expedite or leverage the benefits.

Consider	
At the HHS level	• organisational priorities • leadership support (formal and informal) • organisational demands • access to resources • absorptive capacity, agility, and resilience • local governance, performance, and accountability mechanisms • inter-organisational networks, relationships, and accountability mechanisms • community engagement and participation.
At the system level	• policy drivers and priorities • system level resourcing, governance, performance, and accountability mechanisms • incentives and mandates • inter-organisational networks, relationships, and accountability mechanisms.
Place based	• differences and changes in local context • inclusion of diverse voices, values, and knowledges • First Nations leadership and self determination • inter-organisational networks, relationships, and accountability mechanisms.
Composite assessment	
Metrics	• consideration of potential metrics if identified by the qualitative analysis.
Narrative	• consultation (key informant interviews, stakeholder meetings, community yarns) • desktop research (document and archival review).
Social return on investment	• consideration of the health and social benefits from changes if they can be linked to a suitable metric.

Evaluation question 14		
Cycle adaptation	1	How are the First Nations leadership reforms at the service and system level contributing to the health equity reform agenda, and what can be done to amplify their impact?
	2	How are the First Nations leadership reforms at the service and system level contributing to implementing the health equity reform agenda, and what can be done to amplify their impact?
	3	How did the First Nations leadership reforms at the service and system level contribute to implementing the health equity reform agenda, and what can be done to amplify their impact?

Purpose

Legislation is viewed as the most powerful lever for structural change. This question ensures the evaluation considers the difference in influence between legislated and relational approaches to transformation, through a focussed examination of the impact of First Nations leadership embedded across the services and system.

Consider	
At the HHS level	• organisational priorities • leadership support (formal and informal) • organisational structure and responsibilities • access to resources • absorptive capacity, agility, and resilience • local governance, performance, and accountability mechanisms • inter-organisational networks, relationships, and accountability mechanisms • community engagement and participation.
At the system level	• purpose and influence of legislation • policy drivers and priorities • leadership support (formal and informal) • system level resourcing, governance, performance, and accountability mechanisms • incentives and mandates • inter-organisational networks, relationships, and accountability mechanisms.
Place based	• differences and changes in local context • inclusion of diverse voices, values, and knowledges • First Nations leadership and self determination • inter-organisational networks, relationships, and accountability mechanisms.

Composite assessment	
Metrics	• consideration of potential metrics if identified by the qualitative analysis.
Narrative	• consultation (key informant interviews, stakeholder meetings, community yarns) • desktop research (document and archival review).
Social return on investment	• consideration of the health and social benefits from changes if they can be linked to a suitable metric.

Evaluation question 15		
Cycle adaptation	1	What approaches to institutionalising and sustaining change have been incorporated into the health equity strategies or implementation plans?
	2	What changes have been made at the service or system level to institutionalise and sustain learning and success from health equity reform?
	3	What changes have been made at the service or system level to institutionalise and sustain learning and success from health equity reform?

Purpose

Consistent with Learning Health Systems[25], health equity implementation frameworks[23], and continuous quality improvement, this question provides an opportunity to examine how health equity reform is embedding transformation and structural change through institutionalisation and systematisation (policy and procedures).

Consider	
At the HHS level	• organisational priorities • leadership support (formal and informal) • organisational structure and responsibilities • access to resources • absorptive capacity, agility, and resilience • local governance, performance, and accountability mechanisms • inter-organisational networks, relationships, and accountability mechanisms • demands on and resourcing for ATSICCHOs • community engagement and participation.
At the system level	• purpose and influence of legislation • policy drivers and priorities • leadership support (formal and informal) • system level resourcing, governance, performance, and accountability mechanisms • incentives and mandates • inter-organisational networks, relationships, and accountability mechanisms • demands on and resourcing for ATSICCHOs and QAIHC.
Place based	• differences and changes in local context • inclusion of diverse voices, values, and knowledges • First Nations leadership and self determination • inter-organisational networks, relationships, and accountability mechanisms.

Composite assessment	
Metrics	• consideration of potential metrics if identified by the qualitative analysis.
Narrative	• consultation (key informant interviews, stakeholder meetings, community yarns) • desktop research (document and archival review).
Social return on investment	• consideration of the health and social benefits from changes if they can be linked to a suitable metric.

Evaluation question 16		
Cycle adaptation	1	How well can the design and implementation costs of the health equity strategies be captured? What benefits to health outcomes, service improvements, and broader social outcomes will be created by health equity strategies, and how can these be effectively measured?
	2	How are the health equity strategies contributing to positive health outcomes, service improvements and broader social outcomes, and how do these benefits compare to the invested resources?
	3	How have the health equity strategies contributed to positive health outcomes, service improvements and broader social outcomes, and how do these benefits compare to the invested resources?
Purpose		
This question supports the Social Return on Investment analysis as part of the *Health Equity Strategies Monitoring and Evaluation Framework* to address the objective of informing future funding decisions.		

Appendices

4

Glossary

Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs)

From the Hospital and Health Boards Regulation (2012)

In accordance with the Hospital and Health Boards Regulation (2023), an ATSICCHO means a body corporate that has a governing body whose members are Aboriginal people or Torres Strait Islander people elected by a local Aboriginal or Torres Strait Islander community has rules preventing the distribution of the association's property to its members; and delivers health services to the local Aboriginal or Torres Strait Islander community.

Aboriginal and Torres Strait Islander Community Controlled Health Organisations Model of Care

From Making Tracks Together Discussion Paper: A Shared Conversation

The ATSICCHO Model of Care[26], developed with respect and understanding of local historical context and cultural values, ensures that Aboriginal and Torres Strait Islander families feel culturally safe and free from institutional racism when presenting for holistic and comprehensive quality primary health care. Cultural safety is distinguished from cultural 'awareness' as it relates to embedding culturally sound practices into all delivery elements, rather than merely recognising that cultural differences exist. The values and perspectives of local communities shape the design of the delivery of services, evaluation, cultural policies, engagement mechanisms and the physical attributes of our organisations.

Accountability

Developed for the Health Equity Strategies Monitoring and Evaluation Framework

Whilst accountability is often referenced in policy and legislation as an underlying principle or requirement of good governance, it is rarely defined. Accountability requires organisations or individuals to have:

- an understanding, agreement, and acknowledgement of what they are required to do and achieve
- transparency and responsibility for their performance against those requirements
- acceptance of the consequences of their performance, including remedial actions they need to take to improve their performance to the required standards.

Community

From the Hospital and Health Boards Regulation (2023)

In accordance with the Hospital and Health Boards Regulation (2012), the term community refers to a group or organisation consisting of individuals with a common interest. Examples of common interest include the delivery of health services in a particular geographic location, particular health issues, or common cultural background, religion or language.

Community-driven solutions (Aboriginal and Torres Strait Islander)

From Making Tracks Together Queensland's Aboriginal and Torres Strait Islander Health Equity Framework

When Aboriginal and Torres Strait Islander peoples take charge of developing their own strategies, they better reflect their interests, values, vision, and concerns, increasing ownership and accountability[27].

A community-driven approach to health policies and programs is the true reflection of self-determination in health, which will significantly contribute to reducing disparity in health outcomes experienced by Aboriginal and Torres Strait Islander peoples. Upholding a self-determined approach to health gives Aboriginal and Torres Strait Islander peoples complete control of the design and the provision of programs and initiatives appropriate to meet their community needs.

Consumer

From the Hospital and Health Board Regulations (2023)

In accordance with the Hospital and Health Boards Regulation (2023), a consumer can be identified as an individual who uses or may use a health service and is inclusive of that individual's family members, carers, and representatives. It can also include a group of, or organisation for, the individuals mentioned above and includes the representative of the group or organisation.

Continuous quality improvement

From First Nations Health Equity Strategies Health Service Directive QH-HSD-053:2021

Means a deliberate and defined quality management process that is responsive to community needs and concerned with improving population health via incremental improvements in healthcare practices and processes for measurable improvements in outcomes, efficiency, effectiveness, performance, accountability, and/or other quality indicators.

Culturally safe

From the Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021

In relation to the meaning of culturally safe and responsive healthcare services, the Australian Health Practitioner Regulation Agency (AHPRA) states that "Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families, and communities. Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible, and responsive healthcare free of racism."

Decolonising knowledge and practice

Developed for the Health Equity Strategies Monitoring and Evaluation Framework

Decolonising knowledge and practice means countering the dominance of western knowledge by centring Aboriginal and Torres Islander people's priorities and world views in all ways of knowing, being and doing business[28]. The approach does not mean to discard Western knowledge, but to integrate the two knowledge systems where relevant and prioritise where appropriate. In practice, it means understanding the situation from Aboriginal and Torres Strait Islander standpoints to provide culturally valid answers to the evaluation questions and make relevant, practical contributions to the health and wellbeing of Aboriginal and Torres Islander people, as determined by them[28] [29].

Health equity

From Making Tracks Together Queensland's Aboriginal and Torres Strait Islander Health Equity Framework

The World Health Organization defines equity as "the absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. Health equity is achieved when everyone can attain their full potential for health and well-being[30]."

Health equity strategy

From the Hospital and Health Board Act (2011) pt2 div4 s41(c)

A strategy (a health equity strategy) to achieve, and to specify the Service's activities to achieve, health equity for Aboriginal people and Torres Strait Islander people in the provision of health services by the Service.

Holistic concept of health

From Making Tracks Together Discussion Paper: A Shared Conversation

The Aboriginal and Torres Strait Islander concept of health is holistic, incorporating the physical, social, emotional, and cultural wellbeing of individuals and their whole communities. Health is seen in the whole life view for Aboriginal and Torres Strait Islander peoples[31].

The holistic concept also acknowledges the greater influences of social determinants of health and wellbeing including homelessness, education, unemployment, problems resulting from intergenerational trauma, grief and loss, abuse, violence, removal from family and cultural dislocation, substance misuse, racism and discrimination, and social disadvantage[27].

Profound intergenerational impacts of trauma inflicted by racist policies, state-sponsored discrimination, and violence, forced institutionalisation of individuals by government medical officers, the removal of children from families and social marginalisation are visible within the prevalence of mental illness such as depression, violence and self-harm, substance misuse, imprisonment, and inharmonious family relationships[32]. The resulting grief and trauma have been culturally devastating and are inextricable from the identities of present-day Aboriginal and Torres Strait Islander peoples.

Human rights approach

From the Australian Human Rights Commission

A human rights approach means that all efforts should be anchored in a system of rights and corresponding state obligations as established by law. The Australian Human Rights Commission converts human rights principles and laws into practice through:

- Participation: must be active, free and meaningful, and give attention to issues of accessibility.
- Legality: a human rights-based approach requires that the law recognises human rights and freedoms as legally enforceable entitlements.
- Accountability: requires effective monitoring of compliance with human rights standards and achievement of human rights goals, as well as effective remedies for human rights breaches.
- Non-discrimination and equality: all forms of discrimination in the realisation of rights must be prohibited, prevented and eliminated. It also means that priority should be given to people in the most marginalised or vulnerable situations who face the biggest barriers to realising their rights.
- Empowerment: everyone needs to be able to understand their rights, and to participate fully in the development of policy and practices which affect their lives.
- Transparency: decision-making must be transparent to those who are affected by the decisions. People are entitled to understand the reasons behind decisions that concern them, and the process used to arrive at the decision[33].

Institutional racism

From the Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021

For the purpose of the Regulation, refers to the ways in which racist beliefs, attitudes or values have arisen within, or are built into the operations and/or policies of an institution in such a way that discriminates against, controls, or oppresses, directly or indirectly, a certain group of people to limit their rights, causing and/or contributing to inherited disadvantage.

LGBTQISGBB+

Within First Nations communities of Australia, LGBTQIA+ people include Sistergirls and Brotherboys. Sistergirls (assigned male at birth, but with a female spirit and assume traditionally female roles in their community) and Brotherboys (assigned female at birth but with a male spirit and assume traditionally male roles in their community) are collective terms for people who have existed in First Nations communities prior to colonisation, just as in many other Indigenous populations globally. This is why the *Health Equity Strategies Monitoring and Evaluation Framework*, consistent with its de-colonising approach uses the acronym LGBTQISGBB+, and only with reference to First Nations people of Australia.

Partnerships and co-design

From Making Tracks Together Queensland's Aboriginal and Torres Strait Islander Health Equity Framework

The term 'co-design' reflects shared decision-making authority through genuine partnerships. Partnerships require sharing decision-making, power, control, resources, responsibility, and accountability. In partnerships, trust is built and there is an agreed and shared purpose, vision, and intent in working together in a supportive and transparent way. Partners design and review outcomes together and problem-solve solutions. In other words, strategies must include co-design, co-development, co-implementation and co-evaluation with Queensland Health, Hospital and Health Services (HHSs) and ATSICCHOs, which are formalised through agreements.

Place-based solutions

From Making Tracks Together Queensland's Aboriginal and Torres Strait Islander Health Equity Framework

Place-based approaches empower community to participate, lead and own the important initiatives to meet their community needs. The approach is also helpful in breaking down fear and stigma by engaging community, family, and children in their own environment to take charge of their own health and wellbeing. QAIHC's Members, the ATSICCHOs, exemplify the important role place-based approaches have in improving overall health outcomes of Aboriginal and Torres Strait Islander peoples and are best positioned to facilitate the process at the local level. Recognising the different needs of people through place-based solutions creates better results.

Prescribed stakeholders

Development stakeholders are prescribed by the Hospital and Health Board Regulation (2023). In accordance with section 11(D) of the Regulation, the following persons are identified as the development stakeholders: Aboriginal and Torres Strait Islander HHS staff members; Aboriginal and Torres Strait Islander consumers of health services delivered by the HHS; Aboriginal and Torres Strait Islander community members within the HHS service area; Traditional custodians and Native Title holders of land and waters in the HHS service area; and implementation stakeholders.

Implementation stakeholders are prescribed by the Hospital and Health Board Regulation (2023). In accordance with section 13(B) of the Regulation, the following persons are identified as the implementation stakeholders: service-delivery stakeholders for the health equity strategy; the Chief First Nations Health Officer; Queensland Aboriginal and Islander Health Council; and Health and Wellbeing Queensland.

In accordance with the Hospital and Health Board Regulation (2023) **service delivery stakeholders**, in relation to a Service's Health Equity Strategy, refers to Aboriginal and Torres Strait Islander Community-Controlled Health Organisations in the Service's health service area, and/or local primary healthcare organisations in the HHS service area.

Racial discrimination

From the Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021

Defined under the Racial Discrimination Act 1975 (Cth) and has also been further defined in case law. Racial discrimination is defined as the unlawful act of discrimination against a person based on his or her race, colour, descent, national origin or ethnic origin, or immigrant status. The Racial Discrimination Act 1975 (Cth) acknowledges the International Convention on the Elimination of All Forms of Racial Discrimination. Article 2 of the Convention states that, "States Parties condemn racial discrimination and undertake to pursue by all appropriate means and without delay a policy of eliminating racial discrimination in all its forms and promoting understanding among all races."

Racism

From Making Tracks Together Discussion Paper: A shared conversation

Racism is the belief of one's ethnic superiority over other ethnic groups[34] [35] [36]. It is experienced through interpersonal (relationships, behaviours, words) and institutional (structural, systemic, organisational) racism. Freedom from discrimination (which includes racism) is a fundamental human right enshrined in the Racial Discrimination Act 1975 (Cwth) and in the Human Rights Act 2019 (Qld).

Self-determination

From Making Tracks Together Queensland's Aboriginal and Torres Strait Islander Health Equity Framework

Self-determination is a principle preserved in international law. According to law, all peoples have the right of self-determination and "by virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development"[37] [38]. Similarly, according to the United Nations Declaration on the Rights of Indigenous Peoples, "Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions"[39]. For Aboriginal and Torres Strait Islander peoples in Australia, the right to self-determination has and continues to be of fundamental importance in improving health and wellbeing outcomes [40].

ATSICCHOs are practical expressions of Aboriginal and Torres Strait Islander self-determination.

Service agreement

From the Hospital and Health Board Act (2011) pt1 div5 s16

In accordance with the Hospital and Health Board Act (2011), a service agreement, for a Service, means an agreement between the Chief Executive and the Service. Each service agreement states what services will be provided by the Service, and what funding will be provided to the Service to undertake such services, including the way in which the funding to is to be provided.

For example, activity-based funding is a way of funding a health service. In addition, the service agreement will include the performance measures for the provision of services by the Service, as well as the performance data and other data to be provided by the Service to the Chief Executive – including how, and how often, the data is to be provided. The service agreement can include any other matter the Chief Executive considers relevant to the provision of services by the Service.

The service agreement may also deal with matters relating to funding provided by the Commonwealth, without the Commonwealth being a party to the agreement. Additionally, the service agreement may state the circumstances in which a Service (the first Service) may agree with another Service to deliver services for the first Service.

Social justice approach

Developed for the Health Equity Strategies Monitoring and Evaluation Framework

A social justice approach is a way of viewing the world and acting in ways that oppose injustices and inequity while promoting freedom and potential. Social justice is defined as fair treatment, regardless of one's economic status, race, ethnicity, age, religion, citizenship, disability, or sexual orientation. It relates to circumstances into which people are born and live and thus link to the social determinants of health[41].

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Guide to Key Documents

Key health and equity strategy documents There are a number of documents that are available to you as part of the health equity process. These documents were developed with a specific purpose in mind and together aim to provide the tools for developing, implementing, and now evaluating the health equity strategies in partnership with stakeholders.			
Document	**Purpose**	**What the document includes**	**Target audience**
Hospital and Health Board Regulation (2023)	The regulation provides the legal requirements associated with the Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021. This includes the prescribed requirements for the strategy, including the priority areas.	The regulation defines the Prescribed Requirements to fulfil the legal obligations of the Act. The regulation lists the Prescribed Persons who must be party to the development and implementation of a health equity strategy	Everyone
Health Service Directive: First Nations Health Equity Strategies	The Health Service Directive provides a consistent and transparent process to the development of the health equity strategies.	This document includes the requirements relating to the consultation and shared decision-making practice standards, as well as a consistent mediation and conflict resolution process.	HHS
Health Equity Framework	The Health Equity Framework provides an understanding of health equity and the objective to be achieved through the development of a health equity strategy. It provides a summary of the key performance measures as identified in the regulation and the timeframes for implementation and review.	This document includes who the stakeholders are, what co-design means and further information on what the priority areas mean.	HHS and prescribed stakeholders
Health Equity Strategy Template	The Health Equity Strategy Template is a guiding document for HHS (and their partners) that provides a structure to meet the regulatory requirements and ensure there is consistency in the recording and level of detail on the actions to be achieved and their KPIs.	This document includes the required sections for the health equity strategies to be developed. This includes an overview of the structure and guiding instructions for different sections.	HHS and prescribed stakeholders
Health Equity Strategy Toolkit	The Health Equity Strategy Toolkit contains practical tools for the HHS and their partners that will support the development of the actions and collection of the information that is required to complete the template and deliver a health equity strategy.	The toolkit provides practical tools that will assist the completion of the template. These include: accountability framework, partnership agreement, example KPIs, final checklist etc.	HHS and prescribed stakeholders
Health Equity Strategies Monitoring and Evaluation Framework	The Health Equity Monitoring and Evaluation Framework provides guidance for the three system level assessments of the effectiveness and impact of the health equity strategies that will be undertaken between 2023 and 2031.	The framework outlines what needs to be evaluated and its components. These include objectives, scope, principles, program logic, evaluative approach, structure, evaluation questions, and governance arrangements.	HHS and prescribed stakeholders and independent evaluators and evaluation participants

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