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ABSTRACT

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Discussion and conclusion: PLMs highlighted how decolonising practices can inform primary health care programs, though there are limitations. The 'wise practices' PLM is provided to help guide future development. The PLM development approach is crucial to ensure that models reflect Indigenous leadership and priorities and support decolonisation in health care.

Keywords: Aboriginal; Torres Strait Islander; Indigenous; primary health care; decolonisation.

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Introduction:

In Australia, colonisation (as in elsewhere globally) involves the dispossession of Indigenous peoples (Aboriginal and Torres Strait Islander people in the Australian context) and illegal appropriation of lands and the material resources.[1,2] This occurred from 1788 onwards and has given rise to a political marginalisation of Indigenous people within the developing 'white' Australian nation, as reflected in the White Australia policy (the Immigration Restriction Act 1901 which limited the numbers of 'non-white' immigrants to Australia) and continuing policies that exclude appropriate funding to action recommendations.[1,2] The politics of colonialism, and its tools (power, control, policy agendas and institutional structures derived from the British Empire), continue to shape Australian citizens' health and wellbeing - individually, and within communities and populations.[1-3] Colonised systems have profound effects on the lives of Indigenous families internationally, from the time a child is born, to the time of their passing, reducing the health and wellbeing of Indigenous peoples across the human lifespan.[4,5]

Indigenous knowledges and experiences are often misunderstood, undervalued and overlooked, which contributes to culturally unsafe health systems, mistrust and disengagement, and subsequent reduced access to care and preventable ill health and deaths.[4,6] Examples in Australia include the failed referendum designed to create a constitutional enshrined Indigenous voice to the Australian Parliament in 2023 [7], the highest imprisonment rate of any peoples in the world [8], legislation just passed (2024) in the Northern Territory and Queensland that allows for the imprisonment of ten year old children (disproportionally Indigenous), the winding back of truth telling in the state of Queensland, and the underfunding and overly micro managed reporting and regulation regime of services managed and controlled by Aboriginal and Torres Strait Islander communities.[9,10] There are similar examples for Indigenous peoples internationally. For example, in Canada overall care experiences and outcomes remain poor for many Indigenous peoples because of ongoing structural racism and other inequities.[11] Understanding colonial history and its intergenerational effects on Indigenous families lays the foundation for understanding and informing the necessary work to decolonise these systems.

In services such as primary health care decolonising is an ongoing, active process of reimagining and restructuring how services are provided, seeking to mitigate the ongoing harms of injury occurred and health inequities that have particularly deleterious effects on Indigenous peoples.[2] It involves changing the mechanisms of power and control, challenging the status quo, valuing and building on the strengths of communities and promoting community involvement and decision making. An important factor is the extent to which funding, support and resources are available to include Indigenous individuals, families and communities to engage, which takes time. Importantly,

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decolonising practices in services need to be carefully planned and considered. Evaluation and planning tools, such as Program Logic Models, if applied in a decolonising manner, may offer some assistance in supporting this process.

Program Logic Models (PLMs) are a tool to highlight resources and activities that comprise a program, and the changes that are expected to result from them.[12] A PLM may also serve as a framework for planning, implementing and evaluating programs, helping to clarify the theory of change and the assumptions underlying the program's design. A PLM visually represents the relationships between the program inputs (resources), activities, and the outputs and desired/intended outcomes within a particular context. In this way a PLM can help illuminate how a program is designed to contribute to a specific outcome and the rationale and values underpinning it and can assist in evaluating the success of specific programs.[13]

PLM approaches are used extensively in the design and evaluation of primary health care.[14-20] However, there are fewer examples of PLMs in the context of Aboriginal and Torres Strait Islander primary health care in Australia [21]. More generally, there does not appear to be any PLMs that have explicitly sought to examine decolonising practices in primary health care internationally.[22] Decolonising practice is not a stand-alone activity for Indigenous services, but rather an underpinning approach to all their work. We sought to examine if PLMs could promote the nature and rationale of decolonising practice, with the aim of strengthening awareness and understandings of decolonising ways of working, for funders, policy makers, services staff, and the general population.

In this paper we examine how a PLM approach and process can reflect and guide decolonising practices, drawing on five primary health care organisations in Australia working with Aboriginal and Torres Strait Islander people. We analyse key aspects of decolonising practice identified in the PLMs. From this analysis, we developed an Indigenous-informed 'wise practices' PLM that covers the features of the PLMs identified by the services, as well as additional aspects of decolonising practice identified by the researchers, led by the Aboriginal research team. We drew on the principles of 'wise practices' – "locally-appropriate actions, tools, principles or decisions that contribute significantly to the development of sustainable and equitable conditions" [23](p. 19), rather than 'best practice' to recognise the importance of situating practices in their context. [23,24]

In this paper, we use the term 'Aboriginal and Torres Strait Islander' when discussing the project and the Australian context, but when referring to the international context we use 'Indigenous'. In the Australian context, primary health care services that have a focus on Aboriginal and Torres Strait Islander peoples, either through community-controlled organisations or within government services, are often referred to as 'Aboriginal' primary health care services.

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Methods:

This research was part of a National Health and Medical Research Council funded project conducted in partnership with five Aboriginal primary health care services that sought to determine and document decolonising practices in Aboriginal primary health care. Across the project we sought to ground the research in decolonising research methods that focused on listening to and privileging Aboriginal and Torres Strait Islander voices, growing trust, developing partnerships, and bringing an awareness of the power imbalances in health systems and in research.[25] The research team included Aboriginal (no staff identified as Torres Strait Islander) and non-Indigenous researchers. The Aboriginal team met both separately and together with the broader team and the non-Indigenous staff members engaged in ongoing conscious reflection on the role of Aboriginal and non-Indigenous researchers and balancing the need for Indigenous sovereignty and the belief that non-Indigenous researchers need to contribute to addressing colonial systems.

As part of the broader project, we ran PLM workshops with each of five services. Three of the services are Aboriginal community-controlled organisations (Waminda South Coast Women's Health and Welfare Aboriginal Corporation (New South Wales), Central Australian Aboriginal Congress Aboriginal Corporation (Northern Territory); Danila Dilba Health Services (Northern Territory) and the other two are under the umbrella of state government health services structures (Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care (Inala Indigenous Health) and Aboriginal Health Services, Southern Adelaide Local Health Network (SALHN) (South Australia). In developing the project, we worked with each service to identify a specific focus area within their organisation to consider decolonising practices. Waminda elected to have a focus on a health and wellbeing program, Congress on addressing and preventing alcohol-related harm, Danila Dilba on a family support program (Australian Nurse Family Partnership Program), and Inala and SALHN both chose chronic conditions. While the PLM process considered the focus area, the broader service and the ways that they sought to embed decolonising practices in the context at the time was also captured and reflected upon.

Following realist evaluation principles,[26] PLM generally seeks to identify the context, inputs, outputs and outcomes and identify what works, for whom, and in what contexts and why, and can help to elucidate equity considerations. We sought to run the PLM processes in a decolonising way. This included being responsive to the needs of the services and seeking to privilege Aboriginal and Torres Strait Islander perspectives. For example, in the process with Inala staff, we met as a group in the initial modelling process and then split into Aboriginal and Torres Strait Islander and non-Indigenous group discussions, facilitated by an Aboriginal and non-Indigenous facilitator respectively and the

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group then came back together, privileging the Aboriginal and Torres Strait Islander perspectives. This was to ensure a safe space for Aboriginal and Torres Strait Islander staff and knowledges.

We also adapted the PLM process to reflect more contextually meaningful elements of service delivery - for example, rather than speaking of project 'outputs' we focused on 'ways of working' to promote how the services embedded decolonising principles into their everyday practices. In three of the services (Congress, Danila Dilba and Inala) we conducted an initial workshop and then discussed a draft model in a second workshop. In two of the organisations, we conducted only one workshop. After participating in the first workshop, Waminda decided not to participate in the second workshop as their model of care was effectively enabling decolonisation throughout their organisation. They had developed their community-led Waminda model of care, founded on Aboriginal ways of being, knowing, and doing and viewed their approach as already reflecting their decolonising practice rationale. SALHN had experienced considerable staff turnover and after the strains of Covid-19, did not have the capacity to engage in a second workshop.

Thirty-five staff participated in the initial workshops, with smaller (n=14) numbers returning to discuss the draft model in Congress, Danila Dilba and Inala.

The PLMs took a 'systems-based approach', mapping the broader systems within which decolonising efforts operate and emphasising relationships among institutions, stakeholders, and socio-cultural contexts—crucial for understanding structural and systemic transformation.[22] The individual PLMs developed with the services as well as reflections made by staff were examined thematically. Then, after summarising the key components across the five PLMs, we considered the commonalities identified and developed a 'wise practices' PLM guide. The Aboriginal research team met and collectively developed a PLM that reflected essential aspects of decolonising practice, which was then further discussed and refined with the broader team.

The project, including the PLM workshops, was approved by [blinded] ethics committees and written informed consent was obtained from workshop participants.

Findings:

While decolonising practices were embedded in many ways by the services, none of the organisations had previously undertaken a PLM process for the specific programs of focus and the process of developing the PLMs was seen as helping to clarify the underlying principles and rationale of their work in relation to decolonising practice. However, Waminda, while finding the process initially useful, subsequently found that their existing model of wellbeing more accurately reflected the

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decolonising practice that was central to all their work than the PLM did, and felt that the process of developing PLMs in the traditionally structured way did not align to their way of working.

Context:

All services identified historic and ongoing colonisation as the overarching context for their work - as Waminda noted, colonisation is "at the root of all problems." Specific overarching aspects of colonisation were also identified – "less power/control; poverty and inequities in social determinants of health trauma; devaluation of culture; dispossession of land and loss of traditional foods; racism" (Congress). Importantly strengths-based aspects were also noted – "community strengths and resistance" (Congress) and "Aboriginal and Torres Strait Islander ways of knowing, being and doing; resistance, healing, leadership, sovereign rights and interconnectivity" (Inala).

The health system context of perpetuating colonisation was identified. Health systems were explicitly noted to be racist by the services and enacting Western and biomedical views of health (Waminda, Inala and SALHN). Health system funding models were singled out by all services – including short-term and precarious funding leading to high staff turnover; excessive reporting requirements and inappropriate key performance indicators; and under-valuing of Aboriginal and Torres Strait Islander health professionals. For government run services, their situation in the broader health system and leadership structure was also seen as a constraint that led to "tensions" (SALHN) and both government-run services identified the constraints on community input into service design and delivery because of being part of the government health system. Specific service history was also noted as an important contextual feature by the three community-controlled services, with their services coming from needs identified by the community and with a history of community activism.

Specific contextual features of their focus area (for the study) were identified by the three community controlled services. Waminda, which focused on health and wellbeing for the project, identified colonisation as leading to lower levels of power and control contributing to poor outcomes such as poor diet, lower physical activity and lack of access to culturally safe services that all impact wellbeing. Congress had a focus on alcohol and specifically identified colonisation shaping the alcohol policy and industry environment, leading to higher alcohol availability and alcohol consumption that in turn contributed to alcohol-related harm such as involvement with the justice system, family violence, illness and injury and overall impacts on family structure and social and emotional wellbeing. Danila Dilba had a family development focus and again highlighted the impacts of colonisation, most specifically historical policies of removing children (through the Stolen Generations – a government policy where Aboriginal and Torres Strait Islander children were forcibly removed from their families) and subsequent perceptions of white people in government services as

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"judgemental" (e.g. "bossy nurses at the hospital" - Danila Dilba) and associated with fear of their child being removed. Inala and SALHN had focused on chronic diseases but did not specify specific contextual features in relation to this focus, beyond how colonisation shaped the government system that they were part of more generally.

Values:

Underlying values were identified by services, founded in key decolonising aspects and relational worldview foundations. Waminda, and Danila Dilba identified their core values of being "run by community, for community" - Congress similarly describes themselves in this way in their organisational documentation. For Waminda this was highlighted as having Aboriginal women and children at the centre of everything they did, responding to community needs (being "grassroots"), being informed by their board ("never say no to community, say yes and find a way to do it"), staying strengths-based and having culture as foundational. These values were explicit in guiding documents, models of care and cultural and staff wellbeing frameworks. For the wellbeing program specifically, the service also noted "no blame, no shame" highlighting that "all women are on a journey", with the service supporting them "wherever they are at". For Danila Dilba their emphasis is on empowerment, working with mothers who chose to join and a focus on strengths and solutions - "you are an expert in your own life" - and centred on Aboriginal culture. Inala identified their values as being cultural safety, strengths based, relationality and holistic wellbeing.

For Congress and SALHN this was not specifically focused on as part of the PLM process but many of the aspects highlighted above were reflected in their discussions of other aspects of the modelling process.

Inputs:

The services identified a broad array of inputs, both for their organisations in general but also for the specific focus programs. All the services noted staffing as key – this included both the specific number and nature of staff involved, as well as features such as employing community members and involvement of Aboriginal and Torres Strait Islander staff. Community involvement in the service and specific programs and Aboriginal leadership was also noted by all. Knowledge and investment in staff training and education were also identified. Partnerships were highlighted – both with other services in terms of referrals and coordination, within staff teams and most particularly with community members. The importance of cultural protocols, safety and events and celebrations were also stressed.

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Physical places and spaces made available through the services - sometimes across multiple sites - were identified as key inputs as well as specific equipment and supports provided (e.g. gym and kitchen spaces at Waminda).

Activities:

Advocacy for community-controlled services and on social determinants of health more generally (including racism), as well as around the specific area of interest, was noted. For example, SALHN noted their role as participating in committees and working groups to contribute to voice on Aboriginal and Torres Strait Islander health within the state health system they are a part of and providing support to other services in the area, "making them accountable" and addressing "inherent racism".

For program specific aspects, services noted the varied programs that they ran and how the interconnection with other aspects of their services assisted in advancing the focus area as well as reflecting the key foundations for their work. For example, Congress had a focus on action on alcohol supply and provided addiction services but also identified that family structures were undermined by ongoing colonisation and saw family strengthening as a key aspect of their core activities and work in alcohol harm minimisation. Thus, alongside their alcohol focused and general health services, they provided services and advocated on justice and youth detention, family violence, family support groups, pregnancy support, early childhood visiting, parenting preschool readiness and literacy as crucial for social and emotional wellbeing.

Inala and SALHN's project focus was on chronic disease, and alongside a strong health promotion focus and the specific multidisciplinary staff involved in these programs, they stressed the importance of the interconnections of these teams and program features such as outreach, home visiting and walk-in medical appointments as well as assistance with transport and food support. They also noted their intersectoral work with other organisations including policy, justice and welfare organisations and highlighted the key role of referral pathways to connect people into multiple specialist health services and also community controlled services.

Ways of working (outputs):

Services identified important ways of working that reflected their decolonising principles, with some overlaps in the activities they identified. For Waminda their way of working centred on a holistic, person-centred and comprehensive approach that focused on meeting the needs of the women in their community – where everything at the service is delivered in ways that support women and providing advocacy for women. They also noted workforce development processes including employing local women at the service, as well as the training sessions relating to decolonising practice that they

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provided to other organisations and the imperative to "push back" to funders imposing colonising practices.

For Danila Dilba, their ways of working reflected "slow steady gentle work looking for long-term change through empowerment" seeking to support women on their own healing journey and helping to develop skills as well as supporting women in their interactions with other services if requested. Key to this work is establishing connections with Aboriginal people "who's your mob", without "association with the legacy of abuse and colonisation" and the service spoke to the ongoing effects of historical, as well as current, policies on child removal. However, while initially an all-Aboriginal team, the team now has non-Indigenous staff and is seeking to build trust within the team to enable the calling out of white privilege. The service also acknowledges that the program (The Australian Family Partnership Program) they are implementing with first time mothers, while flexible and adaptable, is drawn from a US program (Nurse-Family Partnership Program) [27] which while evidence-based was not developed for Australia, nor for working with Aboriginal and Torres Strait Islander peoples.

Congress focused their discussion on ways of working to address the alcohol and drug-related harm. They highlighted their central role in advocating for better government alcohol policy & against harmful industry practices including excessive alcohol availability. They also noted health promotion to reduce alcohol consumption and provision of additional services and mental health care for alcohol related illness and injury. Their social and emotional wellbeing program also provided family strengthening services and early childhood services such as an allied health program working with children with neurodevelopmental, speech and language development disorders, and an early childhood health and development centre.

Inala identified their multidisciplinary health/allied health interconnected teams and intersectoral approach as an important way of working to address chronic disease. Strong Aboriginal and Torres Strait Islander leadership and inclusion of Aboriginal and Torres Strait Islander staff perspectives were also important, alongside recognising the commitment of staff and valuing their input. Being responsive to community needs and community connections were important, notwithstanding the challenges of responding to this input within a government health service.

For SALHN the commitment and passion of staff and central role of Aboriginal and Torres Strait Islander health professionals who are well embedded in the community was vital. An Aboriginal Health team that was accessible to community members was highlighted as important, as was the need for multiple ways to engage with clients. Similar to Inala, which also had a chronic disease focus, the importance of a multidisciplinary team was noted.

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Outcomes:

Services identified outcomes at both organisational and program levels that underscore decolonising practice as a foundational and necessary element for achieving transformative change. For example, Congress saw their ways of working as contributing to greater community self-determination and community control, as well as striving to reduce the negative effects of ongoing colonisation generally and contributing to the broader task of decolonisation. This includes a governance structure which places decision-making in the hands of Aboriginal community members and actions alcohol and other drugs programs that incorporate both clinical and cultural support (including bush camps and knowledge awareness initiatives co-designed with community members) to shift power back to Aboriginal communities and recognise Indigenous knowledge systems. Waminda noted strong reputation and community support of the service as a "source of strength and pride for the community" as a crucial outcome, as well as staff and leaders feeling invested in the service, with low staff turnover and the service as an important local employer of Aboriginal women.

Reflecting a broader commitment to decolonisation, the services also identified confronting and eradicating racism—particularly within health systems—as a critical outcome. This included not only addressing the direct experiences of racism faced by Aboriginal and Torres Strait Islander communities but also improving access to culturally safe and responsive services, including other health services, as essential steps toward equity, justice and attaining sovereign rights over community wellbeing. Danila Dilba noted a desired outcome of "empowered parents who are more confident in managing life issues including navigating colonised systems and conversing with health professionals, and welfare systems". The need to assist navigation beyond their service, recognised the ways in which health and other services are subject to, and reflect, the colonising forces present in wider society.

Services also identified important outcomes stemming from improvements to social determinants (including better access to health care and other services) and improved chronic disease management and chronic disease prevention (focus area) which contributed to promoting health equity. In some cases, the need for policy and practice change (e.g. in relation to alcohol supply regulation) for this was highlighted.

Some of the services identified intermediate outcomes linked to the different aspects of their program, which were then linked to these longer-term outcomes. For example, for Congress, in relation to decolonising more generally, their work included promoting and increasing individual and collective control, strong Aboriginal and cultural leadership, advocating for legislation and policy change regarding social determinants of health, lessening and better managing the effects of trauma,

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encouraging strong cultural identity and pride in service delivery and reducing experiences of interpersonal and institutional racism. Following from their activities, outcomes related to alcohol were better alcohol policy and an industry environment more conducive to health, reduced alcohol availability and consumption, reduced alcohol-related harm, justice reforms (decreasing levels of incarceration, reduced family violence, reduced alcohol addiction and associated adverse effects through injury and trauma) and improved family functioning. The SALHN Aboriginal Health team strove to ensure their community received good quality care in other service areas and less racism, improved treatment of chronic conditions, support for those managing chronic conditions and prevention of future chronic conditions.

Developing a 'wise practices' PLM

In examining the PLMs from across the project and further reflections from within the Aboriginal research team, the broader project and literature, key components of decolonising practice were identified as constituting Indigenous knowledge-informed 'wise practices' to help guide future PLM modelling (Figure 1). This 'wise practices' PLM is intended as a starting point for services and organisations to conduct their own thinking and planning against these components. While we acknowledge that this 'wise practices' PLM was developed in Australia, we discuss this inclusively to allow for consideration for how this may be relevant for decolonising primary health care for Indigenous peoples in other colonised contexts.[11,28-31]

The *context* section for decolonising practice in this 'wise practices' PLM included the importance of acknowledging both the historical and ongoing effects of colonisation that have occurred through features such as dispossession, invasions/massacres, systemic racism and deficit framing. For example, in the Australian context this includes the historical 'Stolen Generations' government policy of forced removals of Aboriginal and Torres Strait Islander children, and high rates of ongoing child removal. In Canada, high rates of violence against Indigenous women reflects the ongoing effects of colonisation.[32] Importantly context also included acknowledging the unceded sovereign rights of Indigenous peoples and the historical and ongoing resistance to colonisation as well as the healing of Indigenous peoples from trauma. The importance of Indigenous approaches around interconnectivity between and within people as well as to country was also highlighted.

Values identified in this 'wise practices' PLM as underpinning decolonising practice reflected key Indigenous ways of knowing, being and doing.[33] These included understandings of health and holistic notions of wellbeing that incorporated physical, social, emotional, cultural, spiritual, and ecological health of communities. Also important were the principles of self-determination, particularly reflected in community-controlled organisations, as well as the importance of values on collectivity

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and reciprocity. Cultural safety and strengths-based approaches that countered ongoing deficit framings were also identified. Cultural safety is seen here as an explicit effort to centre Indigenous perspectives and knowledges, to mitigate the potential harms when situations aren't safe.

In terms of *inputs* for decolonising practice, the importance of Indigenous ownership and responsiveness was stressed. This included the central role of Indigenous leadership within organisations and the provision of culturally safe environments, including for Indigenous staff. In terms of broader community inputs, engagement with Elders and other knowledge holders as well as the incorporation of traditional healers within services were identified as key. The role of partnerships and networks both with other Indigenous organisations and people, as well as government services, was also important. The integration of Indigenous knowledge into service planning and provision, alongside ensuring that staff were aware of the ongoing effects of continued colonisation and the incorporation of culturally appropriate guidance and frameworks into service planning and delivery were considered important inputs for services. Services also require secure funding and adequate time and flexibility to ensure decolonising practice permeated their organisation. Funding and contractual arrangements work only when not linked to inappropriate (colonising) goals and indicators or subject to unreasonable oversight. Finally, culturally appropriate evaluation and reflexivity of staff and organisations more generally were identified as essential inputs.

The 'wise practices' PLM does not include an activities column, as the components presented in the model are intended to cover any activities services may undertake, whether the activity focus is on chronic conditions, mental health, early childhood, or any other element of primary health care.

In terms of *outputs* or *ways of working*, the importance of Indigenous data sovereignty and accountability (to community) were identified in this 'wise practices' PLM. Indigenous practitioner-led care and culturally safe holistic care (determined by service users themselves rather than providers) that reflected Indigenous understandings of health, as well as the operationalisation of cultural protocols were acknowledged as important ways of working. Appropriate referral pathways and cross agency work as well as advocacy within government services for decolonising practices and 'pushback' on harmful government policies and approaches were also included. Respectful relationship building, with service users, the broader community and other organisations as well as broader community engagement were identified as essential. Staff are often community members also, and supporting all staff to thrive in organisations was stressed. Given the significant effects of the social determinants of health, particularly systemic racism and other forms of discrimination on the health and wellbeing of Indigenous peoples, the importance of action on the social determinants of health was also noted.

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For *outcomes*, self-determining Indigenous peoples and communities and the valuing of Indigenous knowledges and ways of working were identified as fundamental outcomes of decolonising practice. Given the stark health inequities experienced by Aboriginal and Torres Strait Islander peoples in Australia and Indigenous peoples internationally, as well as the focus of the project, improved health and wellbeing was identified as critical. Likewise, the significant ongoing effects of racism for Indigenous peoples meant that reducing racism was crucial. Related to this was the importance of the core notion of trust and its place in sustained and effective collaborations with communities and between organisations. Also included was the importance of services being reflective of, and responsive to, community need and a cyclical notion of growing, learning and evolving.

Discussion:

Our study found that for services seeking to decolonise their primary health care programs to improve health and other outcomes for Aboriginal and Torres Strait Islander people, 'wise practices' PLMs may help to inform and reflect decolonising practices in their organisations. PLM wise practices may also be helpful for evaluation.

The PLM process highlighted the ongoing effects of colonisation on the health and wellbeing of Aboriginal and Torres Strait Islander peoples as well as on PHC services, particularly those who were government managed. More generally, the PLM process with PHC organisations identified key components of decolonised and culturally safe primary health care for Aboriginal and Torres Strait Islander peoples found previously [28,29,34-36] as well as in our broader research.[25,37,38] This included community control and self-determination, resistance, strengths-based approaches, the central role of Indigenous knowledges and the importance of action on the social determinants of health.

Our 'wise practices' PLM built on the PLMs developed by the organisations, to identify components of decolonising practice that could inform and reflect future organisational planning and evaluation. We also sought to expand this 'wise practices' PLM to be inclusive for consideration of other Indigenous peoples – though we acknowledge the limitations of transposing findings from one context to another. Evident throughout the components in this 'wise practices' PLM was the importance of privileging Indigenous ways of knowing, being and doing [33] – both in terms of communities who use services as well as staff who provide and lead services. In line with realist evaluation approaches, the PLMs developed with services in this project emphasised the crucial role of context on the effectiveness of strategies and health outcomes. [21,39] Contextual factors ranged from overarching forces such as ongoing colonisation as the root cause of Indigenous health inequities, through to the broader health system that services were a part of, and local community needs, geography, and history. This was vital to the consideration of ways of working that responded to the

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local community, and to highlight the constraints imposed by the broader system (including funding, workforce issues, and government practices and policies). This reflects key arguments in decolonisation literature on the need for truth telling about the effects of ongoing colonisation, and to shift framing and discourse from a pathologising and deficit discourse of Indigenous health to an emphasis on the colonising history and structures that shape Indigenous adverse health outcomes.[40]

We found realist evaluation's focus of 'what works' [26] also supported extensive discussion and capturing ways of working that were required across the whole organisation to support welcoming, culturally safe access to effective care and health promotion strategies to improve health. The rich data on ways of working allowed Indigenous ways of knowing, being, and doing [33] to be centred and illuminated regardless of the health issue, program being discussed, or funding regimes. Having a community board of management, or other community engagement structures, for example, were not merely a part of the context but an active ingredient in the success of services reaching and serving their communities that shaped all the work undertaken at the services – a necessary input and way of working for decolonising practice. Likewise, the PLM process we conducted supported service staff to define the intended outcomes they valued, rather than the outcomes that might be attached to program funding. This assisted services to centre community priorities, and frame outcomes in terms of decolonising practice – such as building trust and self-determination and reducing racism.

Limitations and implications

This study drew on close collaborative relationships with five primary health care organisations working to decolonise their practice to improve Aboriginal and Torres Strait Islander health and wellbeing and sought to use decolonising practices in the development of PLMs. However, the project was impacted by external factors including Covid-19 and significant staff turnover in the services which affected participation in the workshops, particularly for the second one (blinded reference).

The elements of decolonising practice that informed the 'wise practices' PLM distilled key components that may be potentially useful to organisations in planning, even if not using the PLM process explicitly. PLM has traditionally been a key feature of evaluation. In this instance the focus was less so for the purposes of evaluation, though it may have been useful for the services in this regard. Our process of undertaking the PLM approach identified several learnings that may be helpful for organisations seeking to decolonise and considering PLM to inform planning and evaluation, including how they might meet the 'quintuple' aim regarding seeking to reduce health inequities.[41] While the 'wise practices' PLM was developed in an Australian context we hope that it can contribute to future research and serve as a basis for adapting and tailoring this PLM for other jurisdictions and international contexts.

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Traditional PLMs are often linear and rooted in Western conceptions of evidence and causality. While we sought to decolonise the PLM process as much as we could, as noted, although initially finding the process useful, Waminda felt distilling the work of their organisation into a PLM did not appropriately reflect their decolonising approach – preferring their own models of wellbeing and healing and organisational design processes. The other services found the process useful in articulating the ways that decolonising practice was 'planned' in their organisation. Further consideration of how PLMs are structured and formatted from a decolonising practice perspective could extend their value.

While we considered a particular area of focus for each of the services (which is particularly relevant to evaluation), services also sought to identify service-wide features. At times there was a tension between being able to reflect what was happening more broadly for the service, while focusing on a specific focus area or program. This was an aspect of the PLM process that Waminda felt was particularly constraining, given the integration across their programs and the need for broader and systematic decolonising approaches. The relative emphasis may depend on whether the focus was on general service planning or a specific program for evaluation. We identified the importance of adapting the PLM development process to suit services' existing models of care rather than imposing a new way of considering these models. We were also aware that the PLM discussions were a snapshot in time and in most cases reflected only one aspect of the work of the organisation. While the contextual aspect of the PLMs assisted services to identify potentially constraining aspects of colonisation on their work, it is important to prompt for this throughout the process. In this project the PLMs service model workshops were conducted with staff, rather than directly with community members. While many staff are also Aboriginal and/or Torres Strait Islander community members, including further community members in the process would strengthen the process.

Conclusion:

This paper examines the utility of PLMs for decolonising Indigenous primary health care services and found potential value in highlighting and guiding decolonising practice, and in moving towards health equity. Visually mapping the relationships between program inputs, activities, outputs, and outcomes, offer a culturally meaningful way to realise and embed Indigenous relational worldviews within research. Through their visualisation of interconnected processes of doing and being, these models harness Indigenous epistemologies as essential decolonising methodological approaches—particularly in generating knowledge outcomes aimed at redressing the health inequities experienced by Indigenous peoples and communities globally. While developed in Australia, the 'wise practices' PLM offers a potential starting point for consideration in other colonial contexts such as in Canada and the USA. Our experience suggests that when developed in decolonising ways and privileging

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Indigenous people's voices, experiences and knowledge(s), PLMs have the potential to serve as a valuable tool to document Indigenous-informed ways of working, to educate and advocate to funders, decision makers and policymakers, and to shift the colonial lens. Such work must be staunch and critical to ensure the rights of Indigenous peoples.

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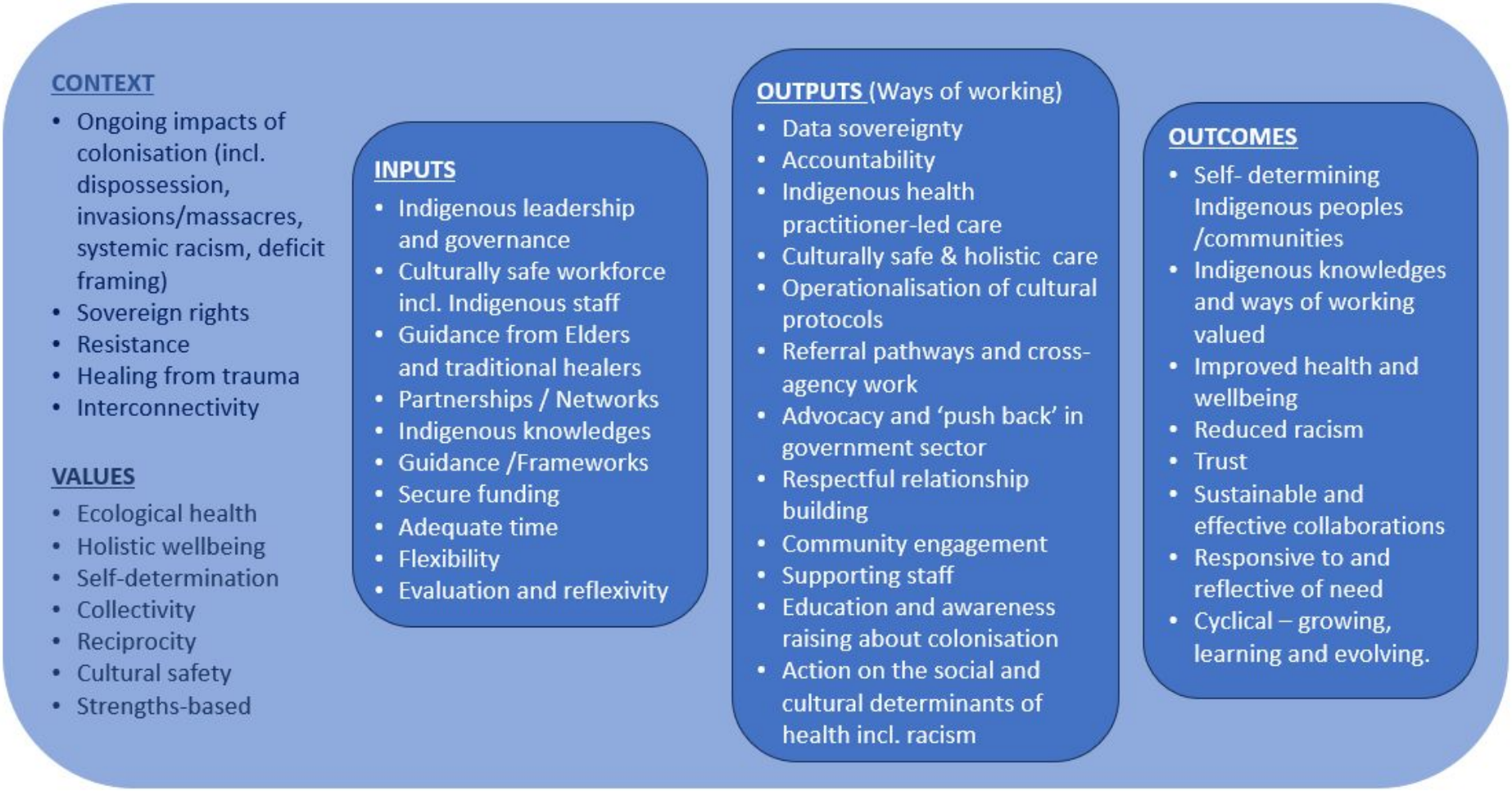

Figure 1: Decolonising 'wise practice' PLM