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RACP Submission to the Productivity Commission's proposed Indigenous Evaluation Strategy

August 2019

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 17,000 physicians and 8,000 trainee physicians, across Australia and New Zealand. The College represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

1. Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to provide a submission to the Productivity Commission's Issues Paper in relation to the Indigenous Evaluation Strategy (the strategy).

This submission focuses on questions in the Issues Paper that are of high relevance to our members' health expertise and experience:

- What objectives should a strategy for evaluating policies and programs affecting Aboriginal and Torres Strait Islander people seek to achieve?
- Which evaluation approaches are best suited to encouraging self-determination and valuing Aboriginal and Torres Strait Islander knowledges?
- Do you agree with the main components of an Indigenous Evaluation Strategy suggested by the Commission? Should other components be included? If so, why?
- What policies and programs affecting Aboriginal and Torres Strait Islander people (or broader policy and program areas) should be the highest priority for evaluation, and why?
- How should an Indigenous evaluation framework differ from a general evaluation framework for government policies and programs?
- What can be done to improve current data governance arrangements?

The context in which many Indigenous programs operate is complex and evolving. Despite this, there are few well-designed and well-executed evaluation strategies that properly measure the effectiveness of these programs in improving outcomes for Aboriginal and Torres Strait Islander peoples, and nothing on the scale or cohesion envisioned by the Productivity Commission. We therefore welcome the development of a long overdue whole-of-government evaluation strategy for Indigenous policy. This will be critical to effective and cost-effective program design, delivery, and accountability.

2. What objectives should a strategy for evaluating policies and programs affecting Aboriginal and Torres Strait Islander people seek to achieve?

Addressing systemic racism and respecting self-determination are important objectives.

The RACP agrees with the key objectives identified in the Issues Paper, which include delivering better outcomes for Aboriginal and Torres Strait Islander peoples and fulfilling obligations under the United Nations Declaration on the Rights of Indigenous Peoples, which Australia (since 2009) has acknowledged as an expression of Aboriginal and Torres Strait Islander people's rights[1]. To ensure the evaluation outcomes work to facilitate and operationalise ongoing self-determination, the processes of policy and program development should be led and driven by Aboriginal and Torres Strait Islander peoples.

[1] Parliament of Australia. Statement on the United Nations Declaration On the Rights of Indigenous Peoples: speech. 2009. https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpressrel%2F418T6%22;src1=sm1

The RACP believes that any meaningful evaluation strategy must establish whether Indigenous policies and programs have acted to reduce or reinforce systemic racism, which is a major contributor to health inequities. There is clear evidence showing that institutional racism can affect the health outcomes of Aboriginal and Torres Strait Islander peoples; as much as 47 per cent of the health gap can be ascribed to institutional racism, interpersonal racism and intergenerational trauma[2]. The extent of systemic racism affecting Aboriginal and Torres Strait Islander peoples demands a clear objective aimed at evaluating whether new policies and programs have reduced systemic racism.

Self-determination is an Indigenous right. As per Australia's adoption of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), the rights of Indigenous peoples and the right to self-determination must be supported throughout policy, program development, delivery and evaluation[3]. The RACP respects self-determination as the bedrock of Indigenous policy and program evaluation and recommends that the next iteration of Commission's Indigenous Evaluation Strategy should explicitly delineate how evaluation can be operationalised in a framework of self-determination – an example of co-design is discussed in the next section. The Chair of the RACP Aboriginal and Torres Strait Islander Health Committee, Associate Professor Luke Burchill, has commented that:

As per the Uluru Statement From the Heart, the "dimensions of our crisis tell plainly the structural nature of our problem. This is the torment of our powerlessness". […]We should recognise that structural barriers and systemic racism impact not only mental health but the entire life course of Aboriginal and Torres Strait Islander people.

The RACP developed an Aboriginal and Torres Strait Islander Health Position Statement[4]. The RACP is a strong supporter of the Uluru Statement from the Heart. We recognise that without self-determination, it is not possible for Aboriginal and Torres Strait Islander peoples to fully overcome the legacy of colonisation and dispossession and its ongoing impacts on health. The ongoing history of colonisation, dispossession and marginalisation have resulted in many Aboriginal and Torres Strait Islander peoples continuing to experience poorer health outcomes. The RACP strongly supports the recognition of the First Peoples of Australia in the Australian constitution. Constitutional recognition is a critical step towards national reconciliation and will contribute to closing the gap in relation to the inequities Indigenous peoples experience, including inequitable health.

Social determinants contribute to health inequities[5]. These determinants are the genesis of many health problems facing Aboriginal and Torres Strait Islander peoples [6]. Whilst it is vital to address all social determinants of health to impact health inequities, we recommend the inclusion of an objective focusing on foundational commitment to self-determination (gauging the degree to which it is realised) and systemic racism (gauging the degree to which it is eliminated).

3. Which evaluation approaches are best suited to encouraging self-determination and valuing Aboriginal and Torres Strait Islander knowledges?

Co-design is the best evaluation approach to strengthen self-determination and value Indigenous knowledge and perspectives.

Policies and programs developed in relation to Indigenous peoples are complex in nature due to a number of considerations including history, colonisation, values, geography and socio-economic factors[7]. The RACP supports a co-design approach involving collaboration between Indigenous leaders and communities and

[2] Bourke CJ, Marrie H, Marrie A. Transforming institutional racism at an Australian hospital. Australian Health Review. 2018 Nov 21

3 United Nations Declaration on the Rights of Indigenous Peoples (Article 23 and 24)

[4] RACP position statement on Aboriginal and Torres Strait Islander Health 2018. https://www.racp.edu.au/docs/default-source/advocacy-library/racp-2018-aboriginal-and-torres-strait-islander-health-position-statement.pdf?sfvrsn=cd5c151a_4

[5] World Health Organisation. Social determinants of Health. https://www.who.int/social_determinants/sdh_definition/en/

[6] Health inequalities and social determinants of Aboriginal peoples' health, National Collaborating Centre for Aboriginal Health, Prince George, British Columbia

[7] T Dreise, E Mazuriski. Weaving knowledge: Knowledge exchange, co-design and community-based participatory research and evaluation in Aboriginal communities.

Australian governments (and their agencies). This is to ensure that evaluations are practical and appropriate to Indigenous communities and most importantly are supported by Indigenous communities.

To ensure co-design integrates diverse perspectives of the Aboriginal and Torres Strait Islander peoples it is essential that we develop frameworks for Indigenous inclusion. Without a framework that promotes 'deep inclusion' of diverse Indigenous life and health experiences there is a significant risk that inequalities observed in the community will be reproduced at the time of consultation. There is also a significant risk of tokenism, where engagement leads to presence without voice and voice without influence. A reliance on narrow Indigenous representation that includes a limited number of stakeholders, with similar life experiences, income or educational levels, substantially increases the risk of generating policies and programs that do not reflect real world concerns or solutions. In addition to considering who should be involved in co-design it is essential that those leading co-design consider how Indigenous people will be involved. In particular, will Indigenous participants have a genuine opportunity to influence the process and if so, how? A range of modes of participation exist, ranging from informing, nominal consultation, and robust consultation to shared decision-making and community control. The former three afford participants less opportunity to raise their voice and be heard. As shown in Figure 1, deep inclusion requires consideration of (1) breadth of stakeholders (2) qualitative equality and (3) high-quality non-elite participation[8].

Fig. 1. Proposed components of deep inclusion. Note: Component in grey encompasses who is included. Components in black encompass how they are included.

In recent decades, Indigenous community-controlled models of health research emerged with the aim to better meet Indigenous community needs[9]. This type of research based on co-design has shown positive outcomes[10]. The NACCHO ear trial provides a practical and successful example of how Indigenous community-controlled health research can be designed, conducted, analysed and applied.

In the framework of self-determination, co-design approach requires equal power of veto between Indigenous decision-making structures and those of mainstream government structures. If an Indigenous organisation determines it has insufficient evaluation culture, capacity and capability, Australian governments should help accelerate their stewardship development. Additionally, Indigenous communities could be assigned evaluation resources with which they can decide the evaluation priorities, select the evaluators, interpret the results, and consequently adjust their programs by themselves or through providing feedback to governments.

[8] Pratt B, Merritt M, and Hyder A A. Towards deep inclusion for equity-oriented health research priority setting: A working model. Social Science & Medicine 151, 2016, 215 - 254

[9] Couzos S, Lea T, Murray R, et al. 'We are not just participants—we are in charge': the NACCHO ear trial and the process for Aboriginal community-controlled health research. Ethnicity & health. 2005 May 1;10(2):91-111.

[10] Couzos S, Lea T, Murray R, et al. 'We are not just participants—we are in charge': the NACCHO ear trial and the process for Aboriginal community-controlled health research. Ethnicity & health. 2005 May 1;10(2):91-111.

The co-design approach can support the contribution of Aboriginal and Torres Strait Islander peoples to deliver better outcomes, and reinforce self-determination and value Indigenous communities' knowledges and perspectives. This approach should be embedded at the beginning of the process, from the research and design phase to implementation and dissemination of evaluation findings. Establishing an Indigenous data sovereignty framework needs to be an essential foundational step in the approach. A systemic review examining the use of experience-based co-design with vulnerable populations found that participants were empowered by offering their insights to health services redesign processes and a shift in the power balance between participants and service providers was also reported[11].

In the Commission's 2012 policy roundtable examining *Better Indigenous Policies: the role of evaluation*, evaluation was defined not solely about producing statistical and qualitative information, but also reaching value judgments about programs and their outcomes[12]. In this respect, the RACP argues that Aboriginal and Torres Strait Islander organisations and peoples should be the ones making these value judgements and decide priorities for evaluation given that these policies and programs are intended to improve their well-being and circumstances.

4. Do you agree with the main components of an Indigenous Evaluation Strategy suggested by the Commission? Should other components be included? If so, why?

RACP Medical Specialist Access Framework can be part of the Indigenous evaluation framework.

The RACP broadly supports the three key prongs of the strategy, namely a principle-based framework, evaluation priorities and processes.

As the Issues Paper notes, there are an array of principles, strategies and frameworks already in place to guide effective evaluations by policy makers and practitioners. The RACP recommends that the Commission incorporate the RACP's Medical Specialist Access Framework (MSAF) in the proposed principles-based evaluation framework.

RACP Medical Specialist Access Framework is Indigenous-led and principles-based.

The MSAF was developed upon the request from the Australian Government to help realise the goals of the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP) 2013–2023, which sets out the required actions to improve Aboriginal and Torres Strait Islander health.

The development of the MSAF was prompted by the concern over lower usage rates of specialist services by Aboriginal and Torres Strait Islander peoples despite higher levels of need. The low use of specialist services has been identified as a contributing factor to the health gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians. MBS data shows that Aboriginal and Torres Strait Islander peoples see specialists about 40 per cent less often than non-Indigenous Australians[13].The MSAF is designed for use across all medical specialties, and other health practitioners as well as funders, planners, and coordinators of specialist care.

With its development led by the RACP Aboriginal and Torres Strait Islander Health Committee, the MSAF is a principle-based framework to underpin equitable delivery of high quality, culturally safe specialist care to

[11] Mulvale A, Miatello A, Hackett C, et al. Applying experience-based co-design with vulnerable populations: Lessons from a systematic review of methods to involve patients, families and service providers in child and youth mental health service improvement. Patient Experience Journal. 2016;3(1):117-29.
[12] Productivity Commission. Better Indigenous Policies: the role of evaluation. Chapter 4: Challenges in evaluating Indigenous policy. 2012. https://www.pc.gov.au/research/supporting/better-indigenous-policies/06-better-indigenous-policies-chapter4.pdf

[13] Australian Government, Australian Institute of Health and Welfare, Aboriginal and Torres Strait Islander Health Performance Framework 2012

Aboriginal and Torres Strait Islander peoples. There are seven key principles in practice, identified as a standard:

1) Indigenous Leadership
2) Culturally Safe and Equitable
3) Person-Centred and Family Orientated
4) Flexibility
5) Sustainable and Feasible
6) Integration and Continuity of Care
7) Quality and Accountability

The MSAF is a valuable resource for Australian Government agencies, in that its principles bolster policies and programs that aim to improve specialist access and achieve equitable health outcomes for Aboriginal and Torres Strait Islander peoples. It derived from the consensus reached in a policy roundtable with 35 experts in the area of Indigenous health from Australia, held in 2014 by the RACP. Moreover, the MSAF can be adapted to different models of care, be they Indigenous-specific or mainstream programs.

The principles outlined in the MSAF should be considered both a guide and a standard for funders, facilitators and service delivery organisations. As such, we believe these principles are a sound basis for any consideration of health care systems within the evaluation process.

We recommend the MSAF be implemented in national, state and territories health plans as well as included in the Indigenous evaluation framework.

Effective and meaningful policy and program evaluation should identify explicitly who exactly will be receiving the evaluation findings, what their decision-making delegation is and what their options will be based on the evaluation findings.

5. What policies and programs affecting Aboriginal and Torres Strait Islander people (or broader policy and program areas) should be the highest priority for evaluation, and why?

Closing the Gap and the Indigenous Australians' Health Programme are the specific policies that are of the highest priority for evaluation.

As a medical organisation, the RACP focuses on improving health outcomes for Aboriginal and Torres Strait Islander peoples. Thus, we recommend that the COAG/Commonwealth's initiatives on Closing the Gap and the Commonwealth's Indigenous Australians' Health Programme should be the highest priority for evaluation.

Closing the Gap is the overarching Indigenous policy strategy of the Australian governments, in response to the Close the Gap Campaign (of which the RACP is a founding member). This campaign is built on evidence that health equality for Aboriginal and Torres Strait Islander peoples is achievable by 2030[14]. As pointed out in the recent Closing the Gap (CTG) report 2019, a decade's efforts have resulted in two out of the seven targets on track to be met, but neither of them is an explicit health target.

Given that the majority of the targets are not on track to be met, it is imperative to question whether some of these targets and the strategy that underpins them are appropriate.

While it is reasonable to set targets based on comparison with non-Indigenous Australians, the process of developing policy to meet precisely defined targets meant that Indigenous disadvantage is translated directly into narrow and quantifiable outcome indicators. This may in turn overlook data relevant to broader Indigenous well-being such as incarceration, land rights, cultural integrity, respect for identity and non-discrimination, self-determination, culturally-appropriate education, including Indigenous languages. In this regard, Australian

[14] Australian Human Rights Commission. Close the Gap: Indigenous health campaign. https://www.humanrights.gov.au/our-work/aboriginal-and-torres-strait-islander-social-justice/projects/close-gap-indigenous-health

governments may consider broadening the categorisations of relevant indicators on which the development of future Indigenous policies and programs could be based.

The principles of equitable specialist access (MSAF) should be taken into consideration when evaluating Indigenous policies and programs against CTG targets in that its principles are an essential foundation of any successful model of health care: they are "both a guide and a standard[15]".

We strongly support the Coalition of Peaks, the Closing the Gap Partnership Agreement and the Joint Council of Australian Governments and Aboriginal and Torres Strait Islander People on Closing the Gap. Shared accountability and responsibility, along with reinvigorated engagement and accountability at the state and territory level, are present for the first time.

With respect to Indigenous Australians' Health Programme (IAHP), the IAHP was instituted in part due of two Closing the Gap targets relating to life expectancy and mortality rates. In line with the Implementation Plan for the NATSIHP 2013-2023 to improve systematic service, the key objective of the IAHP is to provide effective high quality, comprehensive, culturally appropriate, primary health services across Australia. As such, the current evaluation of the IAHP which is underway has a strong emphasis on co-design, and may provide a model in terms of design. This model also includes the establishment of a Health Sector Co-design Group (HSCG) and appropriate ethics review processes by Human Research Ethics Committees (HREC). This is imperative for any evaluation strategy.

We understand that alignment is being sought between the refreshed CTG indicators and the indicators in the Implementation Plan for the NATSIHP 2013-2023. The MSAF is a deliverable of part 1B of the Implementation Plan, with implementation to be undertaken across the health system within jurisdictions.

The RACP supports the Aboriginal Community Controlled Health sector, which is of vital importance in delivering effective, culturally safe care to Australia's First Peoples. The sector must have long-term, legislated, sufficient and secure funding to both retain and grow its capacity, including greater integration with to specialist services. Any evaluation process needs to recognise and appropriately value how integral the further development and expansion of the Aboriginal Community Controlled Health sector is to improving health outcomes for Aboriginal and Torres Strait Islander peoples.

6. How should an Indigenous evaluation framework differ from a general evaluation framework for government policies and programs?

An Indigenous evaluation framework should differ from general evaluation framework.

Compared to non-Indigenous Australians, Aboriginal and Torres Strait Islander peoples face different sets of challenges. The data shows that for Aboriginal and Torres Strait Islander men and women born 2015-2017, their life expectancies were estimated to be around 8-9 years less than that of non-Indigenous males and females[16]. Programs and policies targeted at Aboriginal and Torres Strait Islander peoples may have different principles and values at their core, especially if they are designed and led by Aboriginal and Torres Strait Islander peoples. This means that the criteria for good Indigenous policy development and delivery are different, and consequently so should an Indigenous evaluation framework be different.

The RACP stresses that an Indigenous evaluation framework must be Indigenous led, principle-based and take into account human rights-based, values-based and knowledge-based approaches. In the RACP's Indigenous Strategic Framework, a framework for action within the RACP, we underscore that any strategic initiatives are more likely to be successful if based on Indigenous aspirations and priorities, fitting within an Indigenous framework and process, and placed in the context of Indigenous self-determination. Indigenous leadership, agency and decision making is critical from the beginning of the process, and throughout the implementation, evaluation and knowledge translation phases. Moreover, to truly benefit Aboriginal and

[15] MSAF p. 8.
[16] Australian Indigenous HelathInfoNet. Overview of Aboriginal and Torres Strait Islander health states 2018. https://apo.org.au/sites/default/files/resource-files/2019/03/apo-nid223386-1336326.pdf

Torres Strait Islander peoples, an Indigenous evaluation framework must be designed to identify and measure systemic racism and its consequences.

Outcome disparity is a defining characteristic of institutional racism[17]. Systemic or institutional racism against Aboriginal and Torres Strait Islander peoples not only harms health and wellbeing across generations, but is associated with entrenched disadvantage. This cause of Indigenous ill health is also recognised in the National Health and Medical Research Council Road Map[18].

A Victorian Population Health Survey found that Aboriginal and Torres Strait Islander peoples aged 18 or over experienced racism four times higher than non-Indigenous Australians in the last 12 months in Victoria[19]. This lead to the study suggesting that racism directed against Aboriginal and Torres Strait Islander peoples in Victoria is a significant problem[20]. Given the extent of this problem, the Australian government agencies must strive to reduce racism and its flow on effects across generations.

We support the inclusion of the strategies outlined on page 30 of the Issues Paper[21] for incorporating Aboriginal and Torres Strait Islander knowledges, priorities and perspectives during evaluation:

- evaluations being led and conducted by Aboriginal and Torres Strait Islander evaluators
- co-design of evaluation plans between government agencies, evaluators and Aboriginal and Torres Strait Islander people
- strengthening involvement of Aboriginal and Torres Strait Islander staff and organisations in data collection and analysis phases of evaluation (see comments on Indigenous data sovereignty)
- using or privileging Aboriginal and Torres Strait Islander research methodologies
- Aboriginal and Torres Strait Islander representation on project steering committees
- presenting evaluation results to Aboriginal and Torres Strait Islander stakeholders
- oversight by Aboriginal and Torres Strait Islander evaluation committees

Another important principle in evaluation is free prior and informed consent by those who are being "evaluated". As discussed in the previous section, the current evaluation of the IAHP includes the establishment of Aboriginal led Health Sector Co-design Group to provide oversight by Aboriginal and Torres Strait Islander peoples of all evaluation processes – this oversight role is essential and should be included in the strategy.

7. What can be done to improve current data governance arrangements?

Indigenous data sovereignty must be respected and supported.

Data is key to any evaluation process and respect for Indigenous data sovereignty must underpin this entire process. The lack of adequate and relevant data on Indigenous peoples is a key challenge identified by national and international bodies. Presently, there is greater awareness of and progress toward Indigenous data sovereignty in many jurisdictions. To this effect, Indigenous governance and participation in data collection processes must occur. Sufficient financial and technical resources must be provided so that data collection and disaggregation can be achieved[22].

The RACP supports Indigenous data sovereignty, which is defined as the right to govern the creation, collection, ownership and application of their data[23]. We believe that this right is based on Aboriginal and

[17] Bourke CJ, Marrie H, Marrie A. Transforming institutional racism at an Australian hospital. Australian Health Review. 2018
[18] Cooperative research centre for Aboriginal health. The impact of racism on Indigenous health in Australia and Aotearoa: Towards a research agenda. 2008.
[19] Markwick A, Ansari Z, Clinch D, McNeil J. Experiences of racism among Aboriginal and Torres Strait Islander adults living in the Australian state of Victoria: a cross-sectional population-based study. BMC public health. 2019 Dec;19(1):309.
[20] Markwick A, Ansari Z, Clinch D, McNeil J. Experiences of racism among Aboriginal and Torres Strait Islander adults living in the Australian state of Victoria: a cross-sectional population-based study. BMC public health. 2019 Dec;19(1):309.
[21] Productivity Commission Issues Paper: Indigenous Evaluation Strategy, June 2019
[22] Kukutai, T. and Taylor, J. eds. 2016. Indigenous Data Sovereignty: Towards an Agenda (Vol. 38) ANU Press.
[23] Kukutai, T. and Taylor, J. eds. 2016. Indigenous Data Sovereignty: Towards an Agenda (Vol. 38) ANU Press.

Torres Strait Islander peoples' inherent rights to self-determination and that Indigenous data sovereignty is beneficial for self-determination and overcoming health inequities and disadvantage.

The key mechanism to realising Indigenous data sovereignty is through Indigenous data governance, which refers to the right of Indigenous peoples to autonomously decide what, how and why Indigenous data are collected, accessed and used so as to ensure that those data reflect the priorities, values, cultures, worldviews and diversity of Indigenous peoples[24]. In the view of the RACP, improving Indigenous data governance necessitates first an acknowledgement of implicit colonial bias by non-Indigenous Australians that data collection and its subsequent utlilisation is intrinsic to the maintenance of power and the perpetuation of colonisation's power imbalances.

While it is vital for Australian governments to embed data governance across policies and programs affecting Indigenous peoples, this mandates consideration of the existing and future capacity of the Indigenous community to lead this work and achieve these objectives. Therefore, to achieve its outcome of Indigenous led evaluation, the strategy must provide tangible information on how it will build capacity among Aboriginal and Torres Strait Islander people so that they can lead Indigenous data governance. This includes provisions to assert sovereignty over the choice of indicators[25] and to contest decisions based on indicators.

Equally as important is ensuring this strategy includes requirements that Aboriginal and Torres Strait Islander peoples have data sovereignty and decision-making power in the translation of this information from the development of the evaluation reporting to the way it feeds into policy design and program implementation processes and how this information is disseminated and shared. As the Letter of Direction states[26] that in developing the strategy, "…the Commission will consider how to translate evidence into practice and to embed evaluation in policy and program delivery.", then it is essential that the strategy includes reference to how Aboriginal and Torres Strait Islander people will lead that knowledge translation process.

The RACP is also of the view that:

- To achieve the aims of the Indigenous Evaluation Strategy, the number of Indigenous leaders with the necessary statistical, community and cultural expertise to lead the processes must be increased significantly.
- Supporting Aboriginal and Torres Strait Islander peoples in exercising their right to data governance should run in parallel with considerable investment in Indigenous training programs, particularly those focused on building essential skills in program evaluation such as statistics.
- Consideration needs to be given to the perspectives and needs of existing Aboriginal and Torres Strait Islander leaders already engaged in Indigenous data governance, policy and program evaluation, including compensation or support commensurate with their expertise and contribution.

8. Other comments about evaluation

We would also like to raise the following point for the Commission's consideration:

- For policies or programs that impact Indigenous people and that lack a strong evidence base, we suggest that a better governmental response would be to conduct research or pilots under conditions that will most likely to generate the evidence needed and consider what needs to be evaluated.

[24] Indigenous data sovereignty Communique. 2018. http://www.aigi.com.au/wp-content/uploads/2018/07/Communique-Indigenous-Data-Sovereignty-Summit.pdf
[25] Kukutai, T. and Taylor, J. eds. 2016. Indigenous Data Sovereignty: Towards an Agenda (Vol. 38) ANU Press. Chapter 6 – Indigenising demographic categories.
[26] Productivity Commission Issues Paper: Indigenous Evaluation Strategy, June 2019, Appendix A, pages 45