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Co-design Versus Faux-design of Aboriginal and Torres Strait Islander Health Policy: A Critical Review

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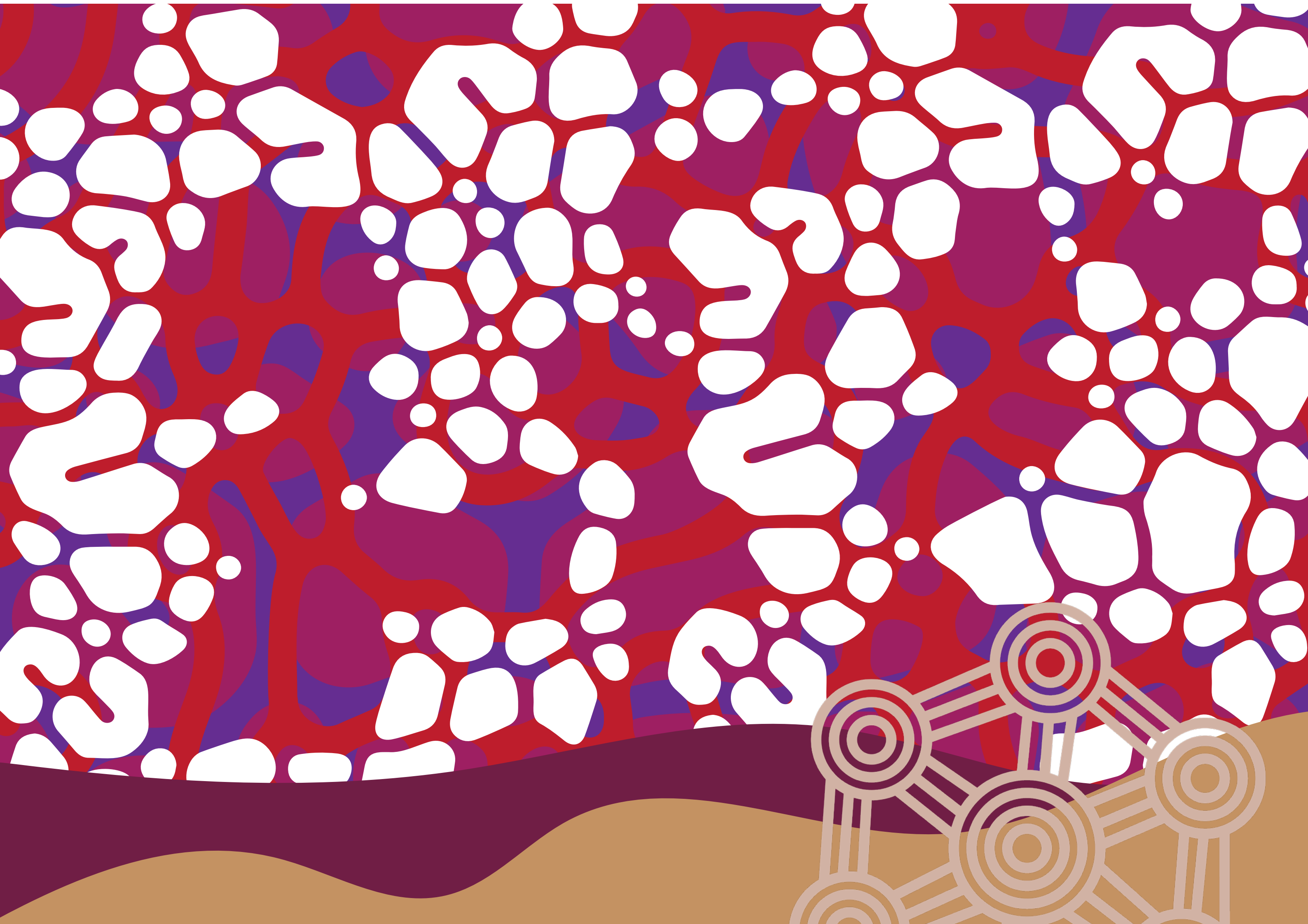

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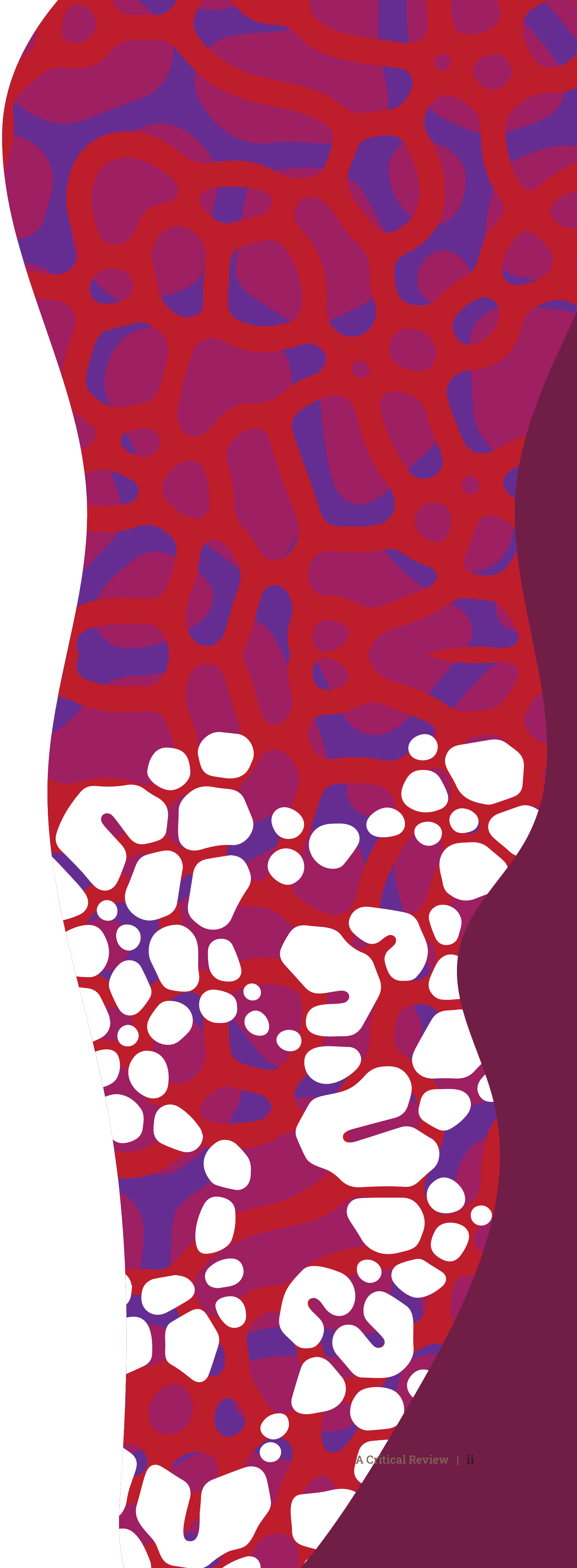


Summary

Australia's health policy landscape operates within a settler-colonial system that continues to perpetuate systemic discrimination. The ongoing failure of health policies to effectively support Aboriginal and Torres Strait Islander peoples is further deepening the inequities brought about by colonisation. Valuing and centring Aboriginal and Torres Strait Islander knowledges, perspectives, and priorities is critical to developing more effective policies.

A co-design approach that centres Aboriginal and Torres Strait Islander peoples, knowledges, values, and practices offers a policy development solution that more effectively addresses prevailing systemic discrimination and inequities. However, while co-design terminology is increasing in Australian health policymaking, many cases apply only tokenistic or superficial co-design practices; an approach that we term ‘*faux-design*’. This paper critically reviews current approaches to co-designing and *faux-design*ing health policy for Aboriginal and Torres Strait Islander peoples.

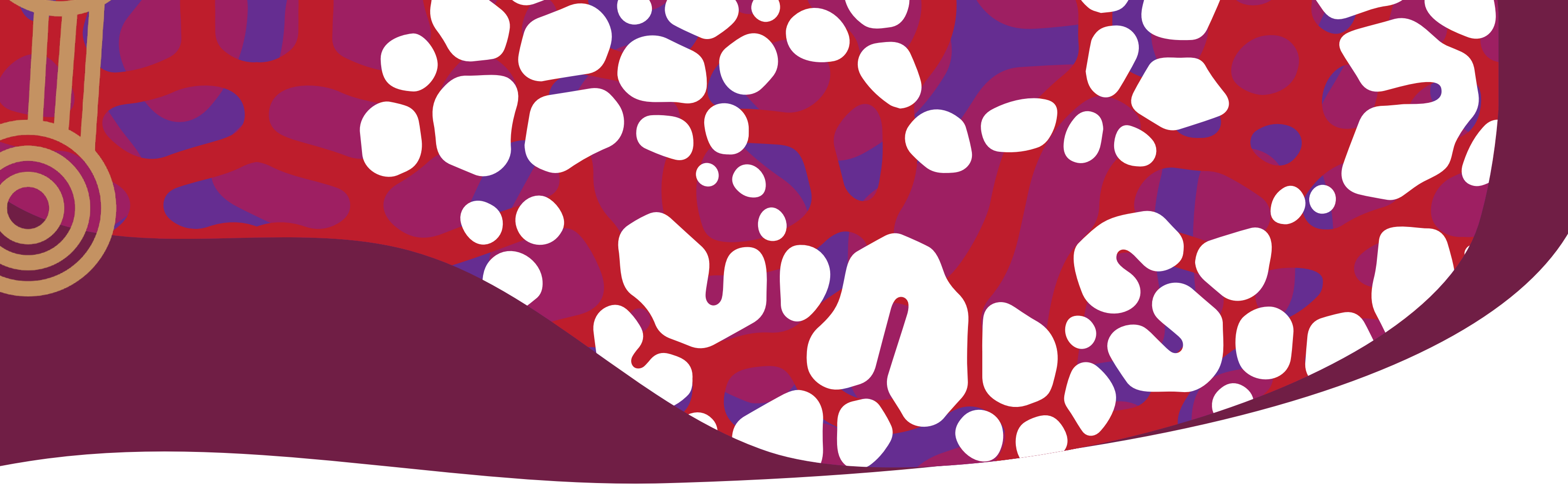
We provide an overview of key concepts, principles and benefits of the co-design methodology; highlight concerns with contemporary practices; and outline critical issues to address to achieve effective co-designed health policies. Case studies are included to illustrate aspects of best practice. Finally, we pose questions to spark debate and shape the future of co-designing policy with Aboriginal and Torres Strait Islander peoples.

Authors

Authors' positionality to this critical review

The authors acknowledge Aboriginal and Torres Strait Islander Traditional Custodians and sovereign owners of the lands and waters where we live and work, the airways beneath which we exist, and their connection to Country. We recognise that sovereignty was never ceded.

Proud Aboriginal and Torres Strait Islander authors (Butler, Black, Gall, Ngampromwongse, Murray, and Whop) bring their personal and professional lived experiences and ways of being to this paper. The authors prioritise self-determined terminology that communicates diversity and sovereignty. The non-Indigenous authors (Anderson, Heris, Mitchell, and Wilkinson) acknowledge the Western knowledge systems and colonial perspectives that shape their worldview and the inherent biases that these perspectives bring. They position themselves as learners in this work.

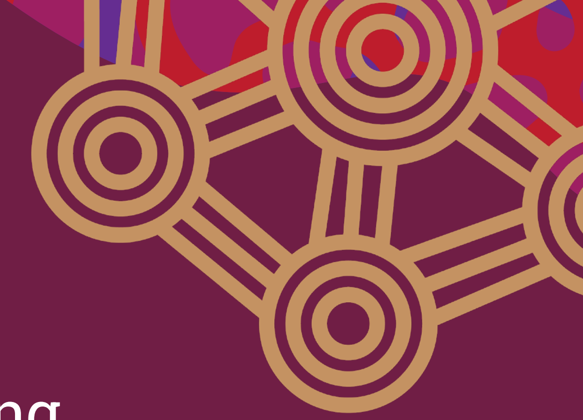


Context for the paper

In late 2024, Lowitja Institute commissioned Yardhura Walani to undertake this critical review and provide a summary and critical comment on current thinking and practices in co-designing health policy with and for Aboriginal and Torres Strait Islander peoples. Yardhura Walani, the National Centre for Aboriginal and Torres Strait Islander Wellbeing Research at the Australian National University, is Australia's largest Aboriginal and Torres Strait Islander health and wellbeing research centre. Our guiding principle is to be in service to Aboriginal and Torres Strait Islander peoples. Our primary vision is to strengthen the health and wellbeing of Aboriginal and Torres Strait Islander communities. We do this is through deep community partnerships; we conduct high-quality health and wellbeing research led by the priorities of communities; we uphold Aboriginal and Torres Strait Islander leadership, governance and ways of doing business; and we create impact at the systems level, informing national-level policy through to community-level impact on programs and services.

Our approach to writing this critical review has been to ensure that our work contributes to improving the outcomes and experiences of Aboriginal and Torres Strait Islander peoples, through the following practices:

- Grounding the development of this critical review in guidance from the highly experienced Yardhura Walani staff and students.
- Ensuring Aboriginal and Torres Strait Islander voices and perspectives are prioritised and privileged throughout all aspects of the critical review development.
- Facilitating collaboration and seeking input from a range of Aboriginal and Torres Strait Islander peoples and non-Indigenous people.
- Building Aboriginal and Torres Strait Islander peoples' research capacity and developing future research leaders.



INTRODUCTION

Co-designing, not faux-designing, effective health policy

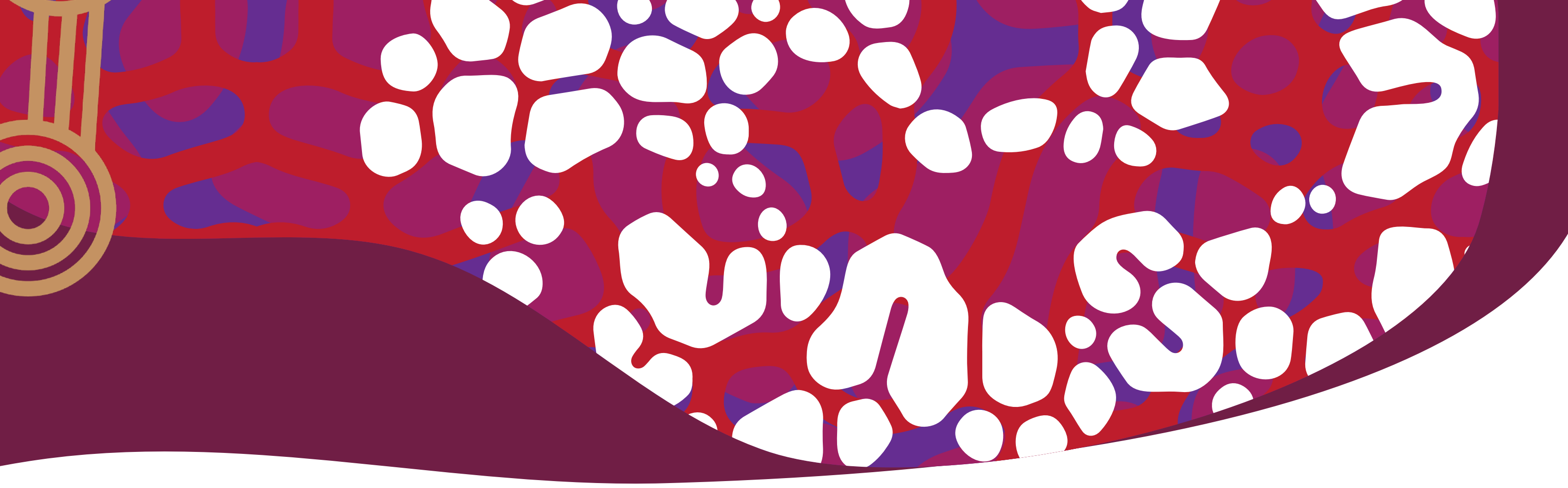
> *‘Co-design is not just about saying sorry for inequity in health research and healthcare delivery, or being sorry for inequality in healthcare outcomes, it is about ‘doing’ sorry’* (Gerrard et al. 2025: 4)

The ongoing impacts of colonisation have led to significant inequities for Aboriginal and Torres Strait Islander peoples (Australian Institute of Health and Welfare 2024). Well-designed policies are essential to support the health and wellbeing of Aboriginal and Torres Strait Islander peoples and redress the prevailing inequity (Jagtap 2022). However, Australian policy development is embedded in a colonial system that perpetuates systemic discrimination (Jagtap 2022, Australian Human Rights Commission 2024). The strongly centralised, top-down approach of Australian policymaking fails to recognise and utilise the value and authority of Aboriginal and Torres Strait Islander ways of knowing, being, and doing (Bridge 2012, Fono et al. 2024). As a result, the current system of policymaking produces ineffective, unsustainable, and unacceptable policy, entrenching poor health and wellbeing outcomes for Aboriginal and Torres Strait Islander peoples.

To address these systemic issues, best-practice co-design aims to empower and actively engage end-users (those directly involved and/or affected by an issue) by collaboratively developing solutions that address the issue of concern (Anderson et al. 2022; King and Cormack 2024; Moll et al. 2020; Slattery, Saeri and Bragge 2020). In policymaking, co-design approaches aim to shift decision-making power from government or institutions to communities, so that community-led decision-making shapes and drives the development of priorities and strategies (Gerrard et al. 2025). As such, co-design policy provides a vehicle to shift power and authority to communities for the betterment of policies and the people affected by them. As Gerrard et al. (2025) note, co-design can go beyond ‘saying sorry’ to ‘doing sorry’.

It is crucial for Aboriginal and Torres Strait Islander peoples to exert their right to self-determination and control over matters that affect their lives and communities. While the 2023 referendum on the Voice to Parliament was unsuccessful, a formal mechanism of the Voice was born from a clear need for Aboriginal and Torres Strait Islander peoples to have a say over the policies that affect them. This need is also clear in terms of health policy, where Aboriginal and Torres Strait Islander communities must be supported to co-design health policies that better meet community priorities. Further, governments and organisations must engage in practices that enable effective best-practice co-design.

The need for best-practice co-design is increasingly important in the current socio-political climate. The National Agreement on Closing the Gap (National Agreement) commits governments to shared decision-making authority with Aboriginal and



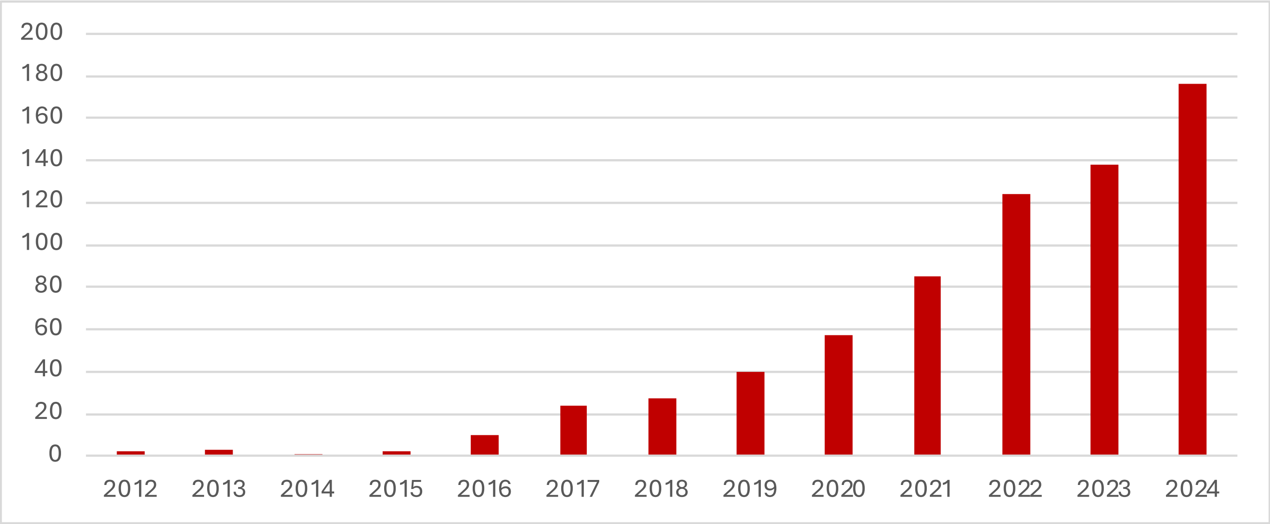
Torres Strait Islander peoples, to better achieve the National Agreement's goals (Dillon 2021; Australian Government 2020). Other major national Aboriginal and Torres Strait Islander health policy frameworks, such as the *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* (Commonwealth of Australia 2021) and the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2021–2031* (Commonwealth of Australia 2022), also commit to co-designing policies and programs with Aboriginal and Torres Strait Islander organisations.

Over the past decade, policymakers have increasingly used co-design approaches, with the aim of developing more effective policies through collaboration with the populations these policies aim to support. Peer-reviewed articles referencing ‘co-design’ and ‘policy’ have more than tripled between 2020 and 2024 (see Figure 1).

While best-practice co-design has the potential to redress the systemic discrimination and inequity experienced by Aboriginal and Torres Strait Islander peoples, there are concerns about its often tokenistic practices in contemporary applications. We term these practices *‘faux-design’*.

This critical review examines current approaches to co-designing health policy with Aboriginal and Torres Strait Islander peoples. We discuss key concepts, principles and benefits of best-practice co-design approaches, highlight concerns about tokenistic practices, and outline critical issues that must be addressed to enact co-design and avoid *faux-design* in policymaking. Case studies are provided to illustrate best-practice co-design. We also pose questions to shape the future of co-designing health policy by and with Aboriginal and Torres Strait Islander peoples.

Figure 1: Number of PubMed search results containing ‘co-design’ and ‘policy’



Key concepts, principles, and benefits of co-design policy

The origins of co-design: The term 'co-design' first appeared in Scandinavian participatory urban planning, architecture, and public service development literature in the 1970s (Moll 2020; Blomkamp 2018). While many definitions now exist, co-design refers to a participatory approach that actively engages end-users to collaboratively develop solutions to address the issue of concern (Anderson et al. 2022; King and Cormack 2024; Moll et al. 2020; Slattery, Saeri and Bragge 2020). Co-design overlaps with approaches like co-production, co-creation, and co-governance, which share practices such as shared decision-making, iterative flexibility, ongoing community engagement, and equitable partnerships (Ansell and Gash 2008; Brandsen and Honingh 2018, Vargas et al. 2022). These approaches view end-users as experts in the issue, making them equal partners in decision-making rather than passive recipients of decisions made by others (King and Cormack 2024; Britton 2017). In recent years, co-design's popularity has grown across research, service delivery, and program development. In Australia, co-design has increasingly become an expected approach in public health policy development, particularly in health policies involving Aboriginal and Torres Strait Islander peoples (Dillon 2021).

Best-practice co-design and its benefits: Co-designed policy allows end-users to meaningfully participate in policy development and implementation. Key principles for effective co-design in Aboriginal and Torres Strait Islander health include that policymaking must incorporate Aboriginal and Torres Strait Islander leadership, respect, community benefit, culturally grounded approaches, inclusive partnerships, and transparency and evaluation (see Table 1) (Anderson et al. 2022; Butler et al. 2022). These principles demonstrate that co-design should be an end-to-end methodology that guides the entire policy development process, not just a method applied during public consultation stages. Best-practice co-design requires community involvement and leadership from the beginning, guiding the process from when community identify concerns to implementing and evaluating solutions and long-term sustainability (Anderson et al. 2022; Butler et al. 2022).

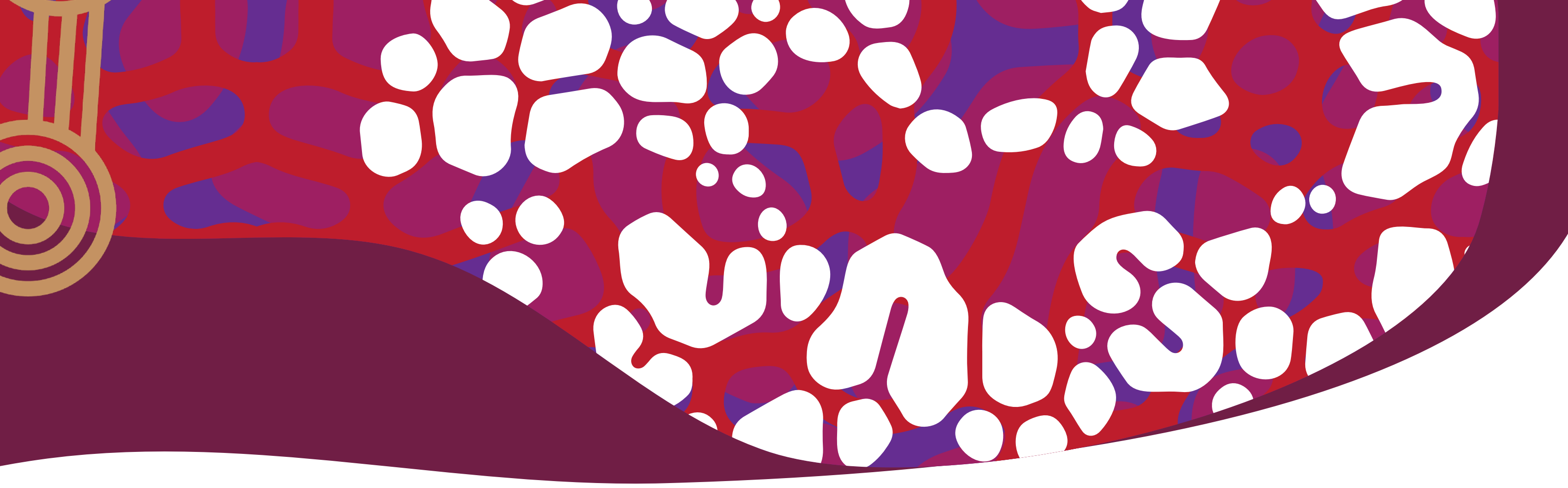


Table 1: Key principles of co-design with Aboriginal and Torres Strait Islander peoples (adapted from Anderson et al. 2022)

PRINCIPLE	SUMMARY
Aboriginal and Torres Strait Islander leadership	Leadership of Aboriginal and Torres Strait Islander peoples in all aspects and every stage of co-design, from early conception through to completion, evaluation, and knowledge sharing. To ensure equity, the balance of power in decision-making needs to rest with Aboriginal and Torres Strait Islander peoples and communities in matters of knowledge, culture, and engagement.
Respect	Co-design must demonstrate respect by allocating ample time, budget, and resources, using a flexible and culturally appropriate approach.
Benefit to community	Co-design must serve Aboriginal and Torres Strait Islander communities and provide real, timely, and sustainable benefits as defined by that community.
Culturally grounded approach	Aboriginal and Torres Strait Islander ways of knowing, being, and doing must be centred in all aspects of co-design. Non-Indigenous people are required to undertake self-reflection, recognition of privilege, and improve cultural competency.
Inclusive partnerships	Partnerships must foster equitable collaboration between all participants, with a focus on conflict resolution processes, communication channels, and building strong and effective relationships not only between individuals but also between organisations, departments and communities.
Transparency and evaluation	Co-design must be accountable to Aboriginal and Torres Strait Islander leaders, with transparent decision-making and monitoring and evaluation built into the project. Project outcomes must be determined by Aboriginal and Torres Strait Islander communities and not predetermined at the outset.

Co-design approaches that enact these key principles ensure that Aboriginal and Torres Strait Islander peoples lead decision-making in issues that affect them, aligning with the tenet ‘nothing about us without us’.

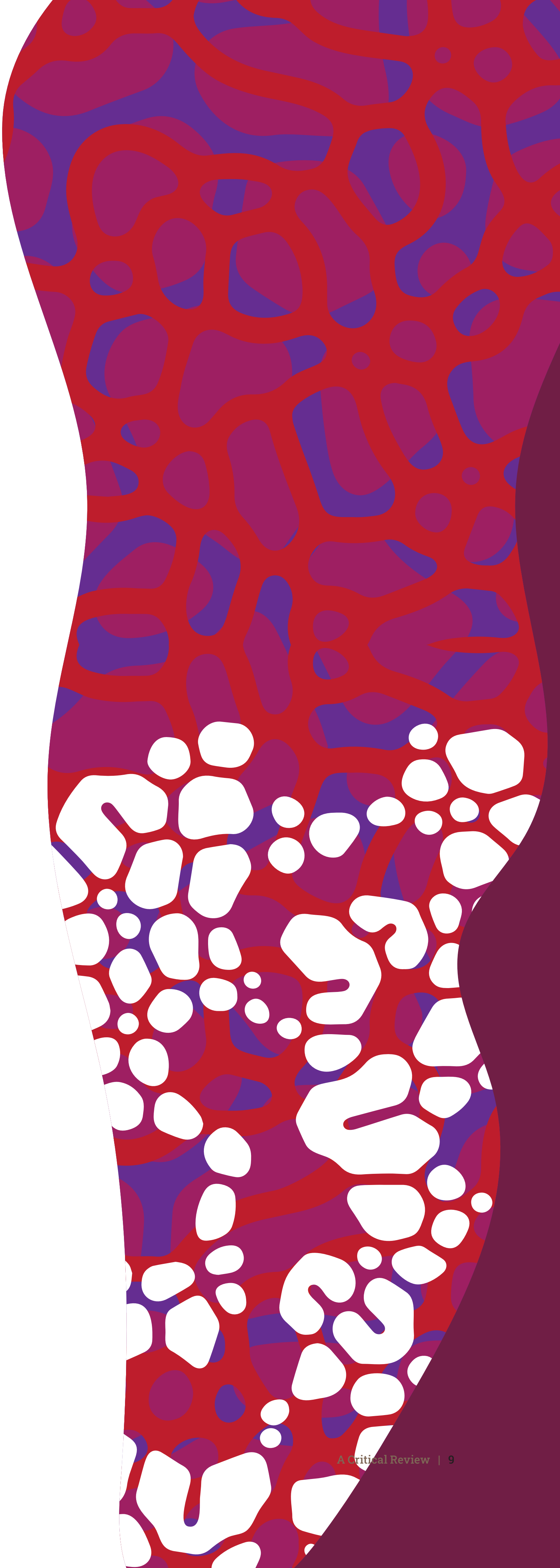
Key benefits of co-designed policy specific to Aboriginal and Torres Strait Islander health are outlined below.

More effective policies and outcomes: Co-design can ensure that programs and policies better reflect community needs, priorities, and lived experiences, leading to culturally relevant solutions (Steen, Manschot and Koning 2011). Such solutions account for the unique practices, values, and worldviews of Aboriginal and Torres Strait Islander peoples as well as the social, structural, and political impacts of ongoing colonisation. Benefits of co-designed policymaking include higher community satisfaction, more creative solutions to complex problems, and greater project success (Blomkamp 2018; Steen, Manschot and Koning 2011). When Aboriginal and Torres Strait Islander cultures and knowledge systems are acknowledged, valued, respected, and incorporated into the co-design process, the resultant policies are more likely to succeed as they offer meaningful and sustainable benefit to the community (Gerrard et al. 2025; Dudgeon et al. 2020; Prior 2007). The outcomes of successful co-design are culturally responsive solutions that are likely to reduce policy failure and inefficiencies (National Indigenous Australians Agency 2023).

Policies grounded in community priorities and processes: The potential benefits of co-designed policies lie not only in the quality of achievable outcomes, but also that the process can facilitate inclusive and collaborative decision-making (Milroy et al. 2022). Aboriginal and Torres Strait Islander collectivist values and practices emphasise relationality and strong community connections. Best-practice co-design requires processes and outcomes to be community driven, where Aboriginal and Torres Strait Islander peoples are not just involved, but collectively lead, control, and own all aspects of the co-design process (Prior 2007; Dudgeon et al. 2018; Dudgeon et al. 2014; Sherwood and Kendall 2013). In other words, the ‘how’ of the co-design process is as important as what meaningful health benefit is produced (Milroy et al. 2022). Co-design promotes practices of power redistribution, ensuring that Aboriginal and Torres Strait Islander voices shape processes and outcomes, and has the potential to strengthen relationships and trust between communities and institutions (Anderson et al. 2022; Butler et al. 2022).

Reduced colonial load: Best-practice co-design values and supports engagement with, and leadership of, Aboriginal and Torres Strait Islander peoples. This prevents tokenism and overburdening (ibid). To achieve this, co-design practices not only locate power with Aboriginal and Torres Strait Islander peoples, but everyone involved in the process is valued and reimbursed fairly for their time and contributions (Aboriginal Health & Medical Research Council of NSW 2020). Co-design includes a need for active and ongoing critical reflection practices by non-Indigenous people as well as two-way learning opportunities and expectations for growth and development for all involved (Sherwood and Kendall 2013).

Platform for social justice: Best-practice co-design centres Aboriginal and Torres Strait Islander voices in policy development, fulfilling an ethical responsibility that is rooted in justice, equity, and human rights (Bond and Singh 2020). This approach aligns Australian policymaking with international standards like the *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)* (United Nations General Assembly 2007), supporting Indigenous sovereignty and self-determination. It requires practices that facilitate engagement and cultural responsiveness and address ongoing exclusions, leading to effective and sustainable outcomes (Butler et al. 2022). This approach positions Aboriginal and Torres Strait Islander peoples as the 'architects of health advancement, rather than accessories to failed health policy frameworks' (Bond and Singh 2020: 199).

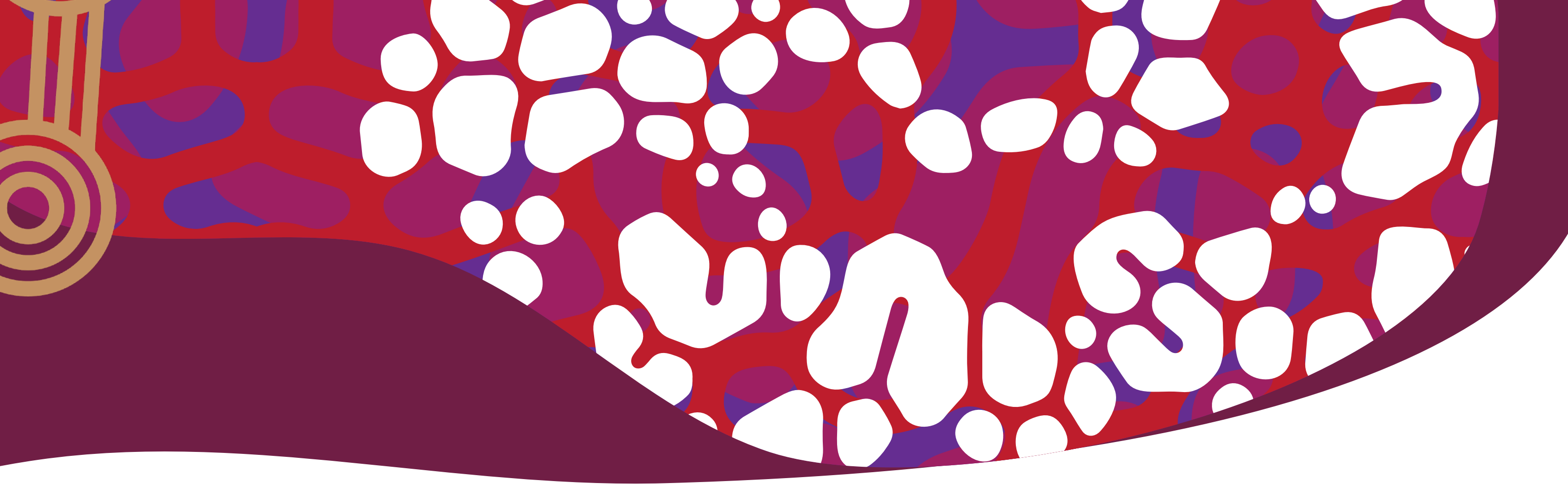


Concerns about tokenistic co-design or faux-design

Despite the benefits of best-practice co-design, concerns are growing that the term is increasingly used as a buzzword in Aboriginal and Torres Strait Islander policy development – often resulting in tokenistic co-design-branded initiatives that lack genuine commitment to key co-design principles (Gerrard et al. 2025). Here we explore some contemporary criticisms about inauthentic and ineffective co-design practices in policy-making – that is, the practice of *faux-design*.

Consultation impersonating co-design: Before co-design became ubiquitous in public policy development, consultation was the popular method for incorporating end-user input (Dillon 2021). Consultation involves seeking the views and perspectives of end-users to inform analysis and decision-making by others. This differs from co-design, which includes end-users as equal partners in decision-making (Dudgeon et al. 2020). The lack of widely endorsed definitions and guidelines for best-practice co-design has led to much co-designed-labelled policy being little more than tokenistic consultation (Gerrard et al. 2025; Dillon et al. 2020). Describing a policy as ‘co-designed’ implies endorsement by Aboriginal and Torres Strait Islander peoples, regardless of the quality of the process. Concerningly, this positions communities as responsible for potential poor co-design outcomes, absolving the involved governments and/or institutions of responsibility (King and Cormack 2024). Lack of strong guidance around best practices and, at times, intentionally vague application of co-design processes, has led to the growth of *faux-design*. This further highlights the need for co-design principles and practices to be developed through Aboriginal and Torres Strait Islander leadership, in order to achieve effectual implementation.

Structural barriers to co-design: Government and administrative cultures and systems can be structural barriers to practices that support co-design, leading to value clashes and process failures (Moll et al. 2020). Organisations commissioning co-design policy often work within fixed constraints (resources, election cycles, staff turnover, time and bureaucracy), which are incongruent with best-practice co-design (Fono et al. 2024; Dillon 2021). Hierarchical implementation and evaluation processes also undermine best-practice co-design. Commissioning organisations and governments often retain tight control over priorities, funding, and decision-making within co-design processes, disguising colonial governance as collaboration (King and Cormack 2024). The development of the co-designed Indigenous Voice exemplifies some of these structural tensions and resulting issues. Michael Dillon’s commentary (2021) on this process describes the government’s pre-determination of the project scope, insistence of media embargoes,

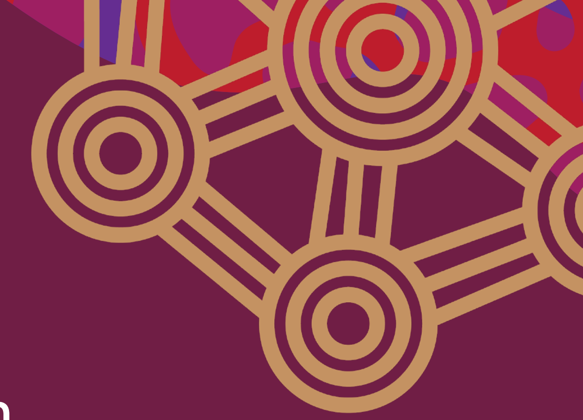


and retaining of veto powers as indicative of the structural barriers to the process. This rendered it more a ‘managed consultation’ than best-practice co-design (Dillon 2021:22).

Inequitable power relationships: Equitable power distribution and decision-making authority are core to co-design practice, yet flawed processes and practices often result in non-Indigenous organisations continuing to wield hierarchical control (Gerrard et al. 2025; King and Cormack 2024; Kennedy Wiradjuri et al. 2024; Tamwoy et al. 2022). Commonly used phrases such as ‘involving community’ and ‘giving back to community’ reflect this power imbalance, which reinforces a hierarchical relationship where communities are positioned as passive recipients rather than equal partners in knowledge creation.

The rise of *faux-design* in policy-making creates culturally unsafe and extractive processes that rebrand colonial harms (ibid).

When power is not genuinely shared, Aboriginal and Torres Strait Islander peoples' right to make decisions about issues that affect their communities and wellbeing is undermined (National Indigenous Australians Agency 2023). Without structural shifts in power relationships, *faux-design* will continue to place non-Indigenous organisations in control of health policy and undermine Aboriginal and Torres Strait Islander peoples’ right to self-determination (Laird et al. 2021).



Moving from faux- to co-design

There is a clear need to improve health policy to better support and benefit Aboriginal and Torres Strait Islander peoples. There is substantial potential for policy improvement through best-practice co-design, however, the concerns around *faux-designed* policy are equally significant. Identifying the path from *faux-design* to best-practice co-design is a critical step in equipping organisations and people to enact co-design that is respectful of Aboriginal and Torres Strait Islander sovereignty. Furthermore, the outcomes from co-designed policy are likely to be more effective than those stemming from *faux-designed* policy. While this paper is not intended to offer a checklist for achieving best-practice co-design, below are some critical issues that must be addressed when taking the journey from faux- to co-designed policymaking.

Locating power with Aboriginal and Torres Strait Islander peoples: For co-design to effectively support Aboriginal and Torres Strait Islander sovereignty, its practices must enact a fundamental redistribution of power (National Indigenous Australians Agency 2023). This positions Aboriginal and Torres Strait Islander peoples as the sole experts in matters relating to their worldviews, relationality, community priorities, and appropriate solutions. Power and leadership in co-design must rest with Aboriginal and Torres Strait Islander peoples, who will ultimately live with the impacts of the policy.

We must move beyond the rhetoric of 'sharing power' to non-Indigenous organisations and governments truly relinquishing power and recognising Aboriginal and Torres Strait Islander sovereignty when setting health priorities and developing solutions for effective policy (Kennedy et al. 2024). This reconfiguring of power relationships calls on non-Indigenous organisations to be in service to the goals and aspirations of Aboriginal and Torres Strait Islander communities (see Table 2). Non-Indigenous institutions must be supportive and not directive, ensuring that power is structurally and permanently transferred to uphold sovereignty, self-determination, and governance (Anderson et al. 2022; Butler et al. 2022). This means dismantling power imbalances, embedding Aboriginal and Torres Strait Islander leadership at every stage, and rejecting tokenistic consultation (King and Cormack 2024). Best-practice co-design must be led by Aboriginal and Torres Strait Islander peoples, organisations, and communities from the outset.

This reconfiguring of power relationships also challenges the frequently overlooked reality that health policy co-design is not limited to partnerships between non-Indigenous organisations and Aboriginal and Torres Strait Islander communities. When Aboriginal and Torres Strait Islander-led groups and communities work together, they begin from a foundation of shared cultural understandings

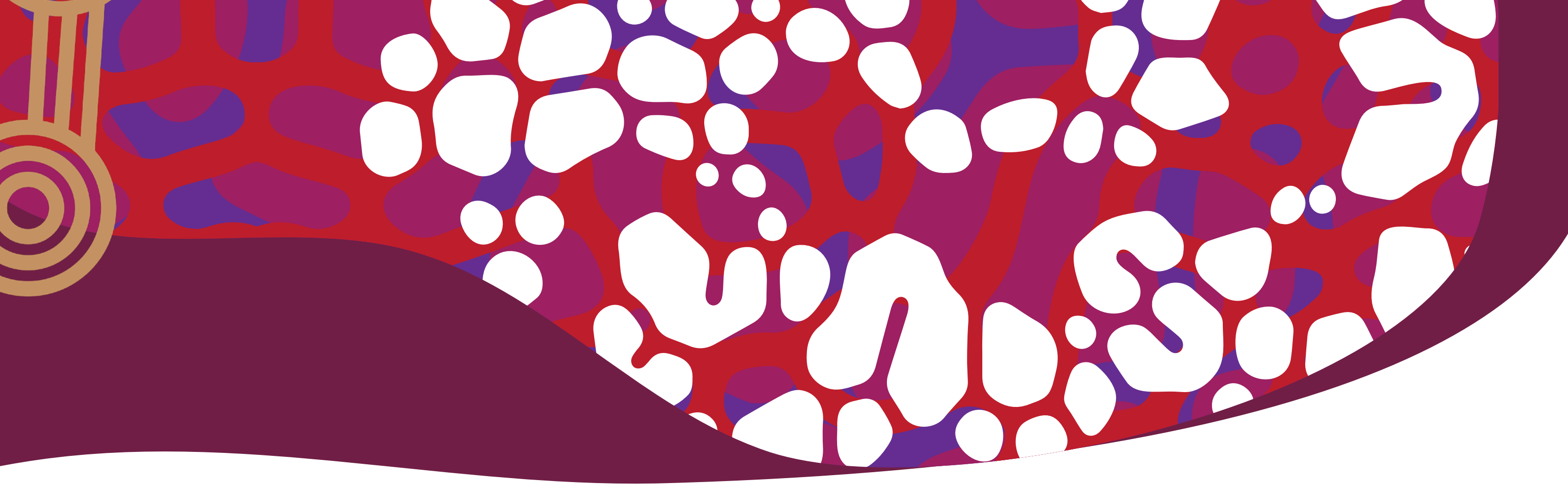


Table 2: Requirements for equitable distribution of power in co-design

REQUIREMENTS FOR EQUITABLE DISTRIBUTION OF POWER IN CO-DESIGN	
✓	An organisational mindset of being in service to Aboriginal and Torres Strait Islander communities and community aspirations.
✓	Commitment to decolonising practices and actively dismantling systemic barriers.
✓	Aboriginal and Torres Strait Islander peoples are the architects of co-design, not just participants.
✓	Non-Indigenous people and institutions actively work to break down colonial power dynamics.
✓	Establishment of genuine, long-term partnerships to develop policy, beginning from the conceptual stage.
✓	Provision of sufficient resources and timelines to enable true collaboration.
✓	Community-led governance structures to ensure authority rests with Aboriginal and Torres Strait Islander peoples.

and mutual recognition of sovereignty. This creates fundamentally different starting conditions for co-design partnerships compared to those involving or initiated by non-Indigenous organisations (see Appendix 1, Case Study 1 as an example).

Centring of Aboriginal and Torres Strait Islander ways of knowing, being, and doing: Best practice approaches to co-design require a shift away from entrenched Western ways of working and thinking that are the current convention in health policymaking (King and Cormack 2024). Best-practice co-design must centre Aboriginal and Torres Strait Islander ways of knowing, being and doing, and align with cultural worldviews. This involves embedding co-design processes in inherently anti-racist and decolonising methods and ensures that policy is developed using methods acceptable and familiar to community. Moreover, the evidence that informs policymaking that impacts Aboriginal and Torres Strait Islander peoples must be collected through rigorous research and enact Indigenist approaches that support Aboriginal and Torres Strait Islander self-determination (Rigney 1999). Indigenist methods – such as Yarning (Bessarab 2010), Dadirri (deep listening) (Ungunmerr-Baumann 2022), and Aboriginal Participatory Action Research (Dudgeon et al. 2020; Milroy et al. 2022) – can be used as part of the policy co-design process.

Aboriginal and Torres Strait Islander evaluation practices are currently being reformed to improve efficacy and accountability of Aboriginal and Torres Strait Islander social and health policy and programs (Maddox et al. 2021; Price, McCoy and Mafi 2012; Productivity Commission 2020). The absence of an Indigenist evaluation methodology has impeded progress in this space, but Indigenist evaluation frameworks and tools that reflect collective capability in evaluation are under development (Maher et al. 2021). Co-design processes being evaluated through the use of Indigenist frameworks and tools is critical to ensure that Aboriginal and Torres Strait Islander ways of knowing, being, and doing are guiding policy review and modification (Maddox et al. 2021; Price, McCoy and Mafi 2012; Maher et al. 2021).

Upholding Indigenous Data Sovereignty: Indigenous scholars worldwide are increasingly leading calls for Indigenous Data Sovereignty (ID-SOV), aligning with UNDRIP supported rights to control data that affects Indigenous peoples. ID-SOV refers to 'the right of Indigenous peoples to exercise ownership over Indigenous data. Ownership of data can be expressed through the creation, collection, access, analysis, interpretation, management, dissemination, and reuse of Indigenous data' (Kukutai and Taylor 2016). In Australia, five principles of ID-SOV have been developed by the Maiam Nayri Wingara Indigenous Data Sovereignty Collective (Maiam nayri Wingara Indigenous Data Sovereignty Collective 2018b).

- Indigenous peoples should exercise control of the data ecosystem, including creation, development, stewardship, analysis, dissemination and infrastructure.
- Data should be contextual and disaggregated (available and accessible at individual, community and First Nations levels).
- Data should be relevant and empower sustainable self-determination and effective self-governance.
- Data structures should be accountable to Indigenous peoples and First Nations.
- Data should be protective and respect our individual and collective interests.

ID-SOV is put into practice through Indigenous Data Governance (ID-GOV), which refers to 'the right of Indigenous peoples to autonomously decide what, how and why Indigenous Data are collected, accessed and used. It ensures that data on or about Indigenous peoples reflects our priorities, values, cultures, worldviews and diversity' (Maiam nayri Wingara Indigenous Data Sovereignty Collective 2018a).

The key principles of co-design and ID-SOV are complementary and share many similarities, such as the centrality of Aboriginal and Torres Strait Islander leadership and decision-making authority; a focus on localised solutions that support self-determination; accountability to Aboriginal and Torres Strait Islander communities; and being grounded in respect for Aboriginal and Torres Strait Islander peoples and cultures. ID-SOV is increasingly understood to be essential for ethical and effective co-design with Aboriginal and Torres Strait Islander peoples (see Appendix 1).

Any co-designed health policy using data about Aboriginal and Torres Strait Islander peoples requires a commitment to uphold and enact ID-SOV through ID-GOV. It is important to note that currently, most

data collected by non-Indigenous government agencies and organisations, by definition, cannot realise ID-SOV principles. This is because this data is collected through non-Indigenous agencies for purposes not deliberately aligned with the interests of, nor controlled by, Aboriginal and Torres Strait Islander peoples. Again, this underscores the need to identify and dismantle structural and systemic barriers to best-practice co-design when developing Aboriginal and Torres Strait Islander health policy.

Practicing guided critical self-reflection: Non-Indigenous organisations and individuals involved in co-design must practice ongoing critical self-reflection on their privilege, power, and understanding of Aboriginal and Torres Strait Islander cultures and knowledges. This can take many forms, including anti-racism training, self-reflection exercises, and supported exposure to different worldviews (Ahpra and National Boards 2025; Australian Institute of Aboriginal and Torres Strait Islander Studies 2025). Ongoing self-reflection is necessary for non-Indigenous people to develop cultural capabilities, responsiveness, and awareness of bias (Gerrard et al. 2025; Anderson et al. 2022; Butler et al. 2022). Reflections should be both internal and relational; should consider the worldview, bias, and perspective the individual brings to the process; and should support understanding of how this impacts relationships and interactions with others as part of the co-design (Moll et al. 2020). Without critical self-reflection, the integrity of the co-design process is undermined.

Strengthening transparency and accountability: Organisations must be transparent about how they plan to conduct co-design and be accountable for the outcomes of co-design processes. This involves conducting thorough and transparent evaluations of the planned policy development process against co-design principles (see Table 1) (Anderson et al. 2022). If the proposed approach does not align with key co-design principles, organisations should consider if they are engaging in *faux-design*. In cases of the latter, the organisations should then not call the approach co-design and instead transparently describe what has been done and/or is being proposed, invite community to determine whether this process is suitable, and be responsive to feedback. This provides organisations with an opportunity to foster transparency and self-reflection, to show that they would like to conduct genuine co-design with Aboriginal and Torres Strait Islander peoples, and to implement high practice and reporting standards. These practices and standards could then also be applied in funding and ethics applications, publications, policy documents, and other outputs, when co-design is reported as being used.

Additional resources and education may be required for non-Indigenous organisations to build the necessary capabilities to achieve improved co-design practices and reporting standards. Availability of such resources and educational tools may also lessen colonial load for communities who decide not to engage in *faux-design* (see ‘no-design’ below). Developing and implementing community-endorsed co-design guidelines and tools requires support from the wider health sector, to ensure consistent and transparent reporting and practices. Similarly, frameworks and tools to support Aboriginal and Torres Strait Islander leadership of associated practices and requirements, including Indigenist evaluation and ID-SOV principles and practices, are also critically important to strengthen health policy development. Over time, these frameworks, guidelines, tools, and standards will strengthen understandings of best-practice co-design and transform practice through high expectations.

Strengthening community capability for *no-design*: One important way to redress *faux-design* is to support and strengthen Aboriginal and Torres Strait Islander peoples' capability for 'no-design' – to decline to be involved in poor co-design processes and so enact self-determination. This refusal of 'whiteness in co-design' is an act of resistance and regeneration that makes space for genuine co-design (King and Cormack 2024). This sends a strong message to organisations that community will not tolerate *faux-design* and that policy development should be done the right way or not at all.

A key principle of best-practice co-design is that Aboriginal and Torres Strait Islander leadership guides the process from the very beginning, starting at issue identification. If Aboriginal and Torres Strait Islander peoples are truly involved in policymaking from the outset, then communities will lead decision-making processes around what, who, how, where, and when the co-design process should occur. Establishing this precursor to co-design largely negates the need for no-design.

Advocating for appropriate funding and approval processes for co-design: Good policy must be underpinned by strong evidence and developed through rigorous research processes. Building this evidence through research requires time and funding. As such, funding schemes form a critical systemic factor that impacts how co-design is conducted. Targeted funding schemes and flexible ethics approaches that allow co-design to be applied are paramount. Those undertaking the co-design must demonstrate respect by allocating sufficient time, budget, and resources, using a flexible and culturally appropriate approach (Anderson et al. 2022). However, most major funding schemes and Human Research Ethics Committees require applicants to outline a detailed proposal with rigid delivery timelines, significant administration, and fees. This discord between the rigidity of funding and approval timelines, and co-design's need for flexibility (in which outcomes and outputs are determined collaboratively as the project progresses) is a major hurdle to overcome within existing systems. Without flexibility, best-practice co-design cannot happen.

Dedicated funding schemes and Human Research Ethics Committees that are responsive to changing timeframes and evolving priorities, will allow applicants to meaningfully describe and apply the full co-design cycle and its outcomes (with success determined by community). There is potential for multi-stage funding models, which first require demonstration of initial relationship-building, expressions of support, and collaborative planning for the project, followed by an invitation to further phase/s with more detailed planning, again with evidence of co-design. Funding schemes that demand full and transparent reporting of co-design processes, both intended and conducted, will also promote better co-design practice overall.

Figure 2 summarises the key characteristics of co-design and *faux-design*. To distinguish between *faux-design* and co-design and support decisions of no-design, communities should ask the co-design initiator the questions posed by Gerrard and colleagues, listed in the middle panel Figure 2 (Gerrard et al. 2025). If the answers are unsatisfactory, communities should feel confident in choosing no-design.

Figure 2: Distinguishing between faux-design and co-design

Distinguishing between Faux-design and Co-design

Deciding factors

- Who controls systems?
- Who determines success?

- On whose terms?
- Who holds power?

- Who holds funding?
- Who is paid?

- Whose cultures are centred?
- Whose knowledges /ways privileged?
- Whose methods?

- Whose benefit?
- Who loses if abandoned or fails?

Faux-design	vs	Co-design
Led by non-Indigenous organisations and governments	**Leadership**	Led by Aboriginal and Torres Strait Islander peoples and organisations
Hierarchical power dynamics located with non-Indigenous organisations	**Power**	Power located with Aboriginal and Torres Strait Islander peoples
Colonial knowledge systems	**Knowledge**	Centres Aboriginal and Torres Strait Islander ways of knowing, being and doing
Predetermined outcomes	**Outcomes**	Community-determined priorities and outcomes
No ID-SOV	**ID-SOV**	Upholds ID-SOV
Opaque and rigid processes	**Processes**	Transparent and flexible processes

Conclusions and key questions

Given the widespread use of co-design terminology and limited evidence of best-practice co-design in Australian health policymaking, it is crucial to provide clear guidance on how collaborative processes can support Aboriginal and Torres Strait Islander peoples to lead the design of solutions when engaging with governments on issues that affect their communities. Best-practice co-design that centres Aboriginal and Torres Strait Islander peoples, knowledges, values, and practices offers a solution for policy development that more effectively addresses prevailing systemic discrimination and inequities. However, if *faux-design* continues to masquerade as co-design, little progress will be made in both closing health and wellbeing gaps experienced by Aboriginal and Torres Strait Islander peoples or redressing the inequities caused by colonisation.

To move forward in this journey from *faux-design* to best-practice co-design, critical reflection and discussion must take place at all levels of government, organisations, and communities. We must collectively interrogate current practices and establish new pathways that support Aboriginal and Torres Strait Islander leadership in policy development. The questions below (Table 3) are intended to spark debate and shape the future of co-designing health policy with Aboriginal and Torres Strait Islander peoples.

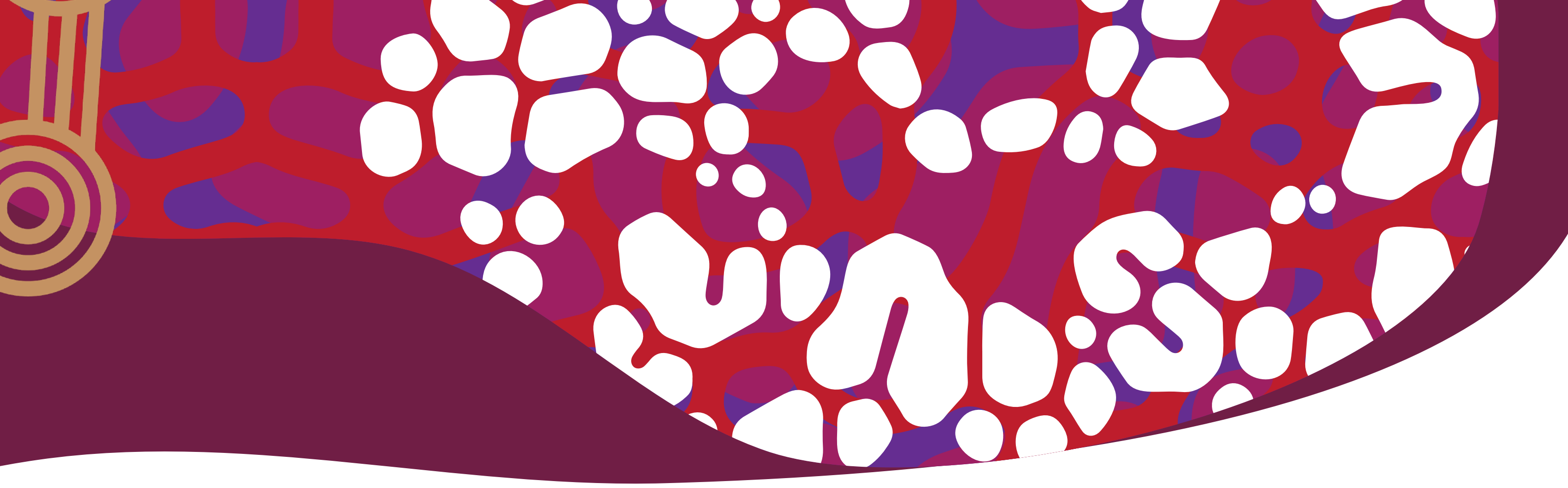
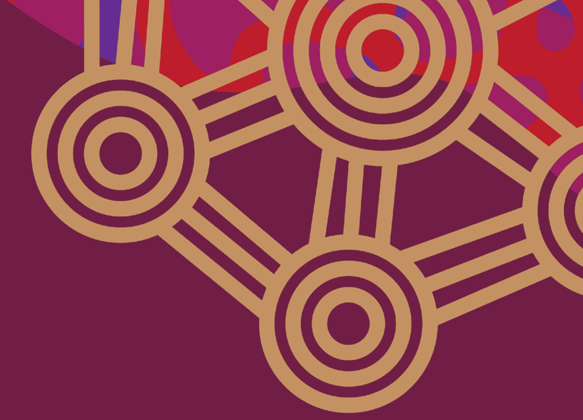


Table 3: Key questions to encourage debate and critical reflection on the journey to best best-practice co-design in Aboriginal and Torres Strait Islander health policy

KEY QUESTIONS	
1.	Is co-design the preferred approach to policy development for Aboriginal and Torres Strait Islander peoples?
2.	Is co-design with Aboriginal and Torres Strait Islander peoples different from co-design with other populations and in other contexts?
3.	How can co-design of national or state-wide policies account for the great diversity of Aboriginal and Torres Strait Islander peoples and cultures?
4.	What changes are required to cede power in policy co-design with Aboriginal and Torres Strait Islander peoples?
5.	How can colonial load be reduced for Aboriginal and Torres Strait Islander peoples engaging in co-design processes?
6.	Are existing evaluation tools for Aboriginal and Torres Strait Islander research (e.g. *the CONSIDER statement* (Huria et al. 2019) or the Aboriginal and Torres Strait Islander Quality Appraisal Tool (Harfield et al. 2020) adequate to assess co-designed policy?
7.	Are national guidelines or checklists for co-designing policy for Aboriginal and Torres Strait Islander peoples needed? If so, how do we prevent co-design from becoming a tick-box exercise?
8.	How can funding and approval structures be modified to better support best-practice co-design?
9.	What support, if any, do Aboriginal and Torres Strait Islander communities need to strengthen capability for no-design?
10.	How should non-Indigenous people and organisations critically reflect on their roles in co-design?
11.	What resources, training, or education is required to ensure best-practice co-design is upheld in Aboriginal and Torres Strait Islander health policy?



Appendix 1

Case studies of best-practice co-design

There are health policy and practice-focused initiatives that demonstrate best-practice co-design for, with, and by Aboriginal and Torres Strait Islander communities. Two examples are presented here that show the benefits of co-design, including how community-led governance, community-driven priorities, and self-determination can create lasting, meaningful policy change. They also demonstrate how best-practice co-design can be enacted in research and policy making. Where possible, we provide examples of what was successful, and reflections learned throughout the co-design process to provide insight into the practical application of co-design.

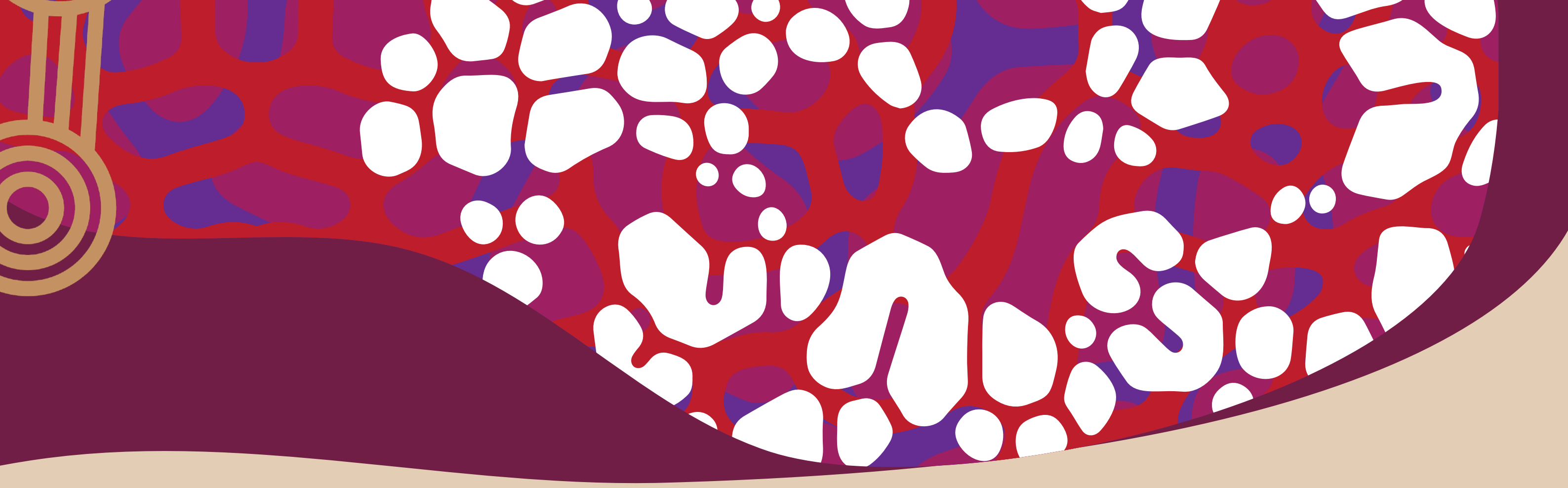
CASE STUDY #1:

Screen Your Way – Community-led cervical screening research project to inform policy and practice

Lead Investigator: Associate Professor Lisa Whop, Yardhura Walani, The Australian National University

Investigators: Assoc Prof Julia Brotherton, Prof Gail Garvey, Dr Tamara Butler, Assoc Prof Mark Wenitong, Assoc Prof Megan Smith, Dr Claire Nightingale, Prof Marion Saville, Prof Rebecca Guy, Prof Joan Cunningham, Claudette (Sissy) Tyson, Sonya Egert, Kristine Falzon, Renee Williams, Prof Karen Canfell, Jacki Mein, Prof Beverley Lawton, Assoc Prof Natalie Taylor, Dr Hamish McManus

Funding: Screen Your Way is funded through an Australian National Health and Medical Research Council Targeted Call for Research competitive funding grant (GNT201490)



The Screen Your Way Aboriginal and Torres Strait Islander Caucus has approved this project being used as a case study in this critical review.

Screen Your Way aims to increase cervical screening participation among Aboriginal and Torres Strait Islander women and people with a cervix by supporting Aboriginal Community Controlled Health Organisations (ACCHOs) to implement locally tailored strategies designed to meet service and community needs. The project was developed in response to Aboriginal and Torres Strait Islander peoples' feedback in previous research, highlighting the need for improved support and access to cervical screening, in particular self-collection.

Screen Your Way is guided by Rigney's Indigenist Research Approach, which respects and prioritises Aboriginal and Torres Strait Islander knowledges, perspectives, and self-determination (Rigney 1999). Governance structures ensure Aboriginal and Torres Strait Islander control and decision-making authority, with decisions made by an Aboriginal and Torres Strait Islander Caucus and oversight provided by Thiitu Tharrmay, an external Aboriginal and Torres Strait Islander reference group, ensuring the research remains culturally grounded.

ACCHOs and the communities they serve determine the strategies and support they require to increase participation in cervical screening. The role of the research team is to support and facilitate strategy identification and implementation. This recognises the expertise of ACCHOs in service delivery, local knowledge, and protocols. Importantly, research funds are managed independently by the ACCHO, respecting their autonomy and ensuring sustainability beyond the research project. The data management agreements and evaluation frameworks are negotiated with ACCHOs, ensuring that these are practical and beneficial to the services and communities.

The ways in which Screen Your Way has enacted the principles of co-design and Indigenous Data Sovereignty are detailed in the table below.

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PRINCIPLE		PRACTICE
Aboriginal and Torres Strait Islander leadership	✓	Led by Gumulgal, Wagadagam researcher Associate Professor Lisa Whop and supported by predominately Aboriginal and/or Torres Strait Islander investigator team.*
	✓	ACCHOs opted in for the study through Board and CEO approval, which included stipulations of the research and data management agreements. ACCHOs are the decision-makers regarding what strategies are implemented.*
	✓	Research governance structures in place, including Aboriginal and Torres Strait Islander Caucus and Thiitu Tharrmay Aboriginal and Torres Strait Islander Reference Group. Caucus comprises Aboriginal and Torres Strait Islander Investigators and functions to make decisions and provide advice and direction on how best to ensure that the project is conducted in an ethical, strengths-based, and culturally safe way. Decisions are then presented to the remainder of the Investigator group. Thiitu Tharrmay provides Aboriginal and Torres Strait Islander leadership, expertise, and advice external to the project.*
	✓	Approval from Aboriginal and Torres Strait Islander-specific human research ethics at national and jurisdictional levels, as well as adherence to local research approval processes.*
	✓	National and jurisdictional ACCHO peak body approval and engagement.*
Respect	✓	ACCHOs are acknowledged as the experts in delivering cervical screenings to their clients and understanding the needs of the community that they serve and the role of the research team as supporting them.*
	✓	ACCHOs provided with funding, to be spent at their discretion to support strategic implementation.
	✓	Participating Aboriginal and Torres Strait Islander community members remunerated for time and knowledge.*
	✓	Cultural branding and design commissioned for the project and produced by Aboriginal and Torres Strait Islander business, Saltwater People.
	✓	Project is co-branded with ACCHOs to facilitate community awareness, engagement, and ownership.
Benefit to community	✓	Clinical training and professional development provided to ACCHO staff.
	✓	Research will be translated into policy through workshops, evidence briefs, and development of a national scale-up plan, describing the common elements of success and proven strategies to improve screening.
	✓	Research developed after research with ACCHOs and community members identified access to cervical screening and self-collection as a priority issue.*
	✓	The project is set up to be of benefit to community – with a theory of change underpinning the research, acknowledging the broader context in which cervical screening is accessed, and seeks to provide a holistic approach.
	✓	Intensive period of co-design is undertaken to understand community needs and to develop the study interventions tailored to each local site.*

PRINCIPLE	PRACTICE
Culturally grounded approach	✓ Research is grounded in Rigney's Indigenist Research Approach (1999).*
	✓ Culturally appropriate research methods used throughout.*
	✓ Diversity in Aboriginal and Torres Strait Islander communities is acknowledged and included through locally tailored approaches.
Inclusive partnerships	✓ Research places ACCHOs and their communities in power, acknowledging that they are best placed to generate locally tailored strategies, and that the role of the research team is to facilitate ACCHOs to implement these strategies.*
	✓ The project has been set up based on equal advice of the team; for example, the study design was influenced by those working within ACCHOs who know what community needs, rather than it being a strict methodological approach, and so the design could be tailored in response to ACCHOs' needs and capacity.*
	✓ Research team and ACCHOs working in partnership with regular and sustained communication.
	✓ Long-standing prior relationships with ACCHOs and sector leaders were prioritised and sustained.
Transparency and evaluation	✓ The evaluation framework is negotiated with the ACCHO, based on what is feasible and of benefit to their cervical screening activities. This means ACCHOs can flag the need for additional evaluation measures if they wish.*
	✓ Quarterly data reports are generated for each site, to provide transparent and timely updates of how the research is tracking. This allows for changes and refinements to be made to strategies as needed.*
Indigenous Data Sovereignty	✓ Strong focus on Indigenous Data Governance, with an Aboriginal and Torres Strait Islander Caucus and external reference group, Thiitu Tharrmay, providing data stewardship.*
	✓ Data agreements ensure power is located within the ACCHO. Each study site determines how their data is used.*
	✓ Research reports provide tailored and disaggregated data to support local decision-making.*
	✓ Data informs the development of locally tailored strategies that meet service and community needs, as determined by the ACCHO.*
	✓ The research team are accountable to services and governance groups.*

*indicates practice that locates power with Aboriginal and Torres Strait Islander peoples, communities, and/or organisations.

Learnings and reflections: Screen Your Way has offered many insights into best-practice co-design partnerships in research that will influence health policy and practice. A key learning has been the need to move beyond the common perception that co-design occurs between Indigenous and non-Indigenous collaborators. Instead, this project has demonstrated that co-design can also take place within Indigenous-led research teams working alongside ACCHOs. This shift has required the research team to redefine their role – not as leaders, but as a support infrastructure that exists to serve and uplift ACCHOs. It has also reinforced the importance of methodological flexibility and rigour, ensuring that research approaches align with community priorities rather than rigid academic frameworks. Additionally, the project has highlighted the need to be readily available, deeply engaged, and unwavering in supporting ACCHOs' ways of knowing. This way of working is vital to ensure Aboriginal and Torres Strait Islander communities have agency and control and can enact their sovereignty and self-determination – in this case, via a research project where the ACCHOs can actively shape the research questions, methods, and interpretation on their terms for their communities.

There are still real and perceived power differentials present in the project. For example, the funding for the project was awarded by the National Health and Medical Research Council to a research team working at a variety of universities (noting that the team includes representatives from ACCHOs and peak bodies). In the current funding structure, this means that the research team and the institutions that employ them still hold some power in how the project is run. Conscious efforts have been made to offset this by locating power with Aboriginal and Torres Strait Islander communities and organisations through co-design practices (for examples, see above points marked with *).


National
Eating Disorders
Collaboration

Evidence Experience Expertise

Eating Disorder Safe principles:

Whole-of-community approaches to do no harm
in relation to eating disorders, disordered eating
and body image distress

July 2024
National Eating Disorders Collaboration

CASE STUDY #2:

Eating Disorder Safe Principles – a policy shaped by community

Project Lead: Dr Alana Gall (Pakana, Truwulway)

Organisation Lead: Hilary Smith (non-Indigenous)

Funding: In-kind support from the National Eating Disorders Collaboration (NEDC) which is funded by the Australian Government Department of Health and Aged Care, and the National Centre for Naturopathic Medicine, Southern Cross University

The Eating Disorder Safe Principles (NEDC 2024) demonstrate how policy can be shaped by Aboriginal and Torres Strait Islander peoples rather than imposed upon them. As part of a national 10-year strategy on eating disorders, this initiative emphasises prevention and harm minimisation, ensuring culturally safe approaches rather than adapting Western biomedical models to an Indigenous context.

Developed through an Indigenous-led co-design process, this initiative embedded Indigenous views throughout the policy and Indigenous healing principles in the companion document, grounded in Indigenous ways of knowing, being, and doing. The process was informed by both-ways Collaborative Yarning and thematic analysis of existing policy documents, conducted by Indigenous researchers. However, unlike many policies developed in non-Indigenous institutional spaces, the draft underwent an iterative co-design process, ensuring Indigenous leadership and governance remained central.

The First Nations Governance Group consisted of nine members, including Indigenous biomedical professionals (including psychology, nursing, and occupational therapy), Indigenous researchers (in fields of nursing, occupational therapy, public health, and psychology), Indigenous health workers and Indigenous peoples with lived experience of eating disorders. An Aboriginal Elder with deep knowledge of eating disorders provided further cultural grounding.

This grassroots-driven approach ensured that decision-making power rested with community members, rather than Indigenous peoples being asked to adapt to existing policies. The Eating Disorder Safe Principles now form part of the *National Eating Disorders Strategy 2023-33*, advancing culturally safe and community-led approaches to eating disorder care. The *First Nations Perspectives: Strengthening the Eating Disorder Safe Principles* is a stand-alone policy but is positioned in the larger Eating Disorder Safe Principles documents as an important part that should be read by all policy users for all populations. This came about due to the feedback of the First Nations Governance Group, who were clear that a) the First Nations Perspectives policy could not be positioned as an option add-on, and b) that Indigenous wisdom should be central to all policy in Australia, not just in policies for First Nations peoples. This positioning of the Indigenous knowledges as important to the underpinnings and understandings of the whole Eating Disorder Safe Principles strongly aligns with the key principles of true co-design, evidencing self-determination of Indigenous peoples.

The ways in which the process to develop the Eating Disorder Safe Principles has enacted the principles of co-design are detailed in the table below.

PRINCIPLE	PRACTICE
Aboriginal and Torres Strait Islander leadership	✓ Led by an Aboriginal researcher and supported by an Aboriginal research assistant.*
	✓ Governance structures in place to prioritise Aboriginal and Torres Strait Islander leadership – Governance comprising 100% Aboriginal and Torres Strait Islander peoples, including health professionals, researchers, and people with lived experience of eating disorders who provided high-level strategic direction over the work.*
	✓ Power and decision-making held with Aboriginal lead.*
	✓ Governance group provided feedback for future work and improvements that the National Eating Disorders Collaboration (NEDC) can do when the next ten-year National Eating Disorders Strategy is developed and implemented. The NEDC has committed to upholding those recommendations*

PRINCIPLE	PRACTICE
Respect	✓ Development of the policy in response to Aboriginal Elder and other Aboriginal people sitting on an Expert Advisory Group for the development of the NEDC Eating Disorder Safe Principles.*
	✓ Policy was developed with respect – Aboriginal Elder, Aboriginal leadership, and Aboriginal and Torres Strait Islander Governance Group all acknowledged as the experts providing their knowledge to the development of the policy.*
	✓ Power remains with the voices of Aboriginal and Torres Strait Islander peoples who informed the research project, and where possible, they will be reengaged for the development of the NEDC's next ten-year national strategy.*
	✓ The artwork on the front of the policy and its accompanying story was designed and written by the Aboriginal research assistant in response to the work they were doing on the underpinning policy review and the new policy development.
	✓ First Nations Governance Group members were reimbursed for their time in meetings and to review documents.
Benefit to community	✓ The underpinning policy review conducted by the Aboriginal research assistant identified that there were no policies for Aboriginal and Torres Strait Islander peoples specific to eating disorders. They also identified a significant lack of research in this area, but the little research available shows eating disorders are more prevalent in the Aboriginal and Torres Strait Islander population than others.
	✓ An Aboriginal Elder spoke to the NEDC about the dire need for an eating disorder policy specific for Aboriginal and Torres Strait Islander peoples.
	✓ The Aboriginal lead for the project was invited by the NEDC to sit on an expert panel for the development of the Eating Disorder Safe Principles. The Aboriginal lead identified that there was a need for a standalone policy as well as for embedding Aboriginal and Torres Strait Islander views into the principles. Without this identified priority it is unlikely that Aboriginal and Torres Strait Islander views would have been included in the policy.
	✓ The development of this standalone policy (which is placed in the Principles document as something everyone should read no matter which population they work with) was developed in response to those community needs and findings of the underpinning policy review.
Culturally grounded approach	✓ The whole policy is grounded in Aboriginal and Torres Strait Islander ways of knowing, being, and doing.*
	✓ The policy outlines a holistic understanding of health and wellbeing and collectivist worldviews.
Inclusive partnerships	✓ The project was set up to ensure that Aboriginal and Torres Strait Islander peoples and views had the ultimate say, but in equal partnership with the NEDC.*
	✓ The policy development utilised both-ways Collaborative Yarning to ensure both Indigenous knowledges and Western knowledge were balanced when analysing data from the underpinning policy review and in the development of the new policy.*

PRINCIPLE	PRACTICE
Transparency and evaluation	✓ The Aboriginal lead and Aboriginal research assistant have ensured that the Governance were kept informed across the whole project, especially of the limitations of the work and what recommendations will be made to the NEDC of what to do differently next time (i.e. that Aboriginal and Torres Strait Islander peoples need to be involved from the start of when the NEDC begins developing its next 10-year strategic plan and not brought in on a related sub-policy).*
	✓ The NEDC conducted a brief process evaluation at the end of the meeting with the First Nations Governance Group, which was important for earlier and fuller engagement in the overall process.

*indicates practice that locates power with Aboriginal and Torres Strait Islander peoples, communities, and/or organisations.

Learnings and reflections: Effective co-design requires detailed planning to ensure all aspects are implemented in meaningful, non-tokenistic ways. While co-design can be achieved at different scales, from small, localised projects to national policy development, the core principles remain consistent. Including diverse (for example, in terms of age, gender, location, cultures, profession, and lived experience) Aboriginal and Torres Strait Islander voices in project governance provides invaluable insights, truly enriching the process and establishing standards for better co-design practices in the future. However, even with careful planning and genuine intentions to implement co-design, significant barriers exist in practice, particularly the reality of limited funding and strict policy timelines that can constrain the flexible, relationship-based approach required by genuine co-design.

This case study is a powerful example of how real and perceived power differentials can be actively identified, addressed, and rebalanced through intentional, culturally grounded co-design practices. Real power differentials are typically related to structural and organisational inequalities, such as who holds decision-making authority, who controls funding and resources, and whose knowledge systems are prioritised. In this case study, the NEDC, is a largely non-Indigenous organisation. Historically, such organisations have shaped policy from a top-down, Western biomedical perspective, often marginalising Aboriginal and Torres Strait Islander voices. This is a clear power imbalance – where Indigenous peoples are often asked to adapt to existing policies rather than shape them. Further, even when real power is offered, perceived power inequalities can persist if Indigenous peoples feel tokenised or sidelined.

In this case, power was not only redistributed in practical terms (through leadership, authorship, and decision-making authority), but it also challenged colonial assumptions about whose knowledge and perspectives are legitimate. By addressing both the structural and symbolic dimensions of power, the Eating Disorder Safe Principles becomes a strong example of how organisations can build equitable partnerships that honour Indigenous sovereignty and leadership. Indeed, Indigenous peoples were not expected to fit into existing policy structures. Instead, the policy structure itself was reshaped to reflect Indigenous leadership, culture, and sovereignty – a hallmark of true co-design and self-determination.

Acknowledgements and References

Acknowledgements

We would like to express our gratitude to senior Yardhura Walani staff, Professor Ray Lovett (Ngiyampaa/Wongaibon), and Fiona Cornforth (Wuthathi, Maluligal), who provided invaluable feedback, advice and direction for this critical review. We also extend our thanks to Yardhura Walani staff and students who provided their advice and experiences at the formative stages of this project.

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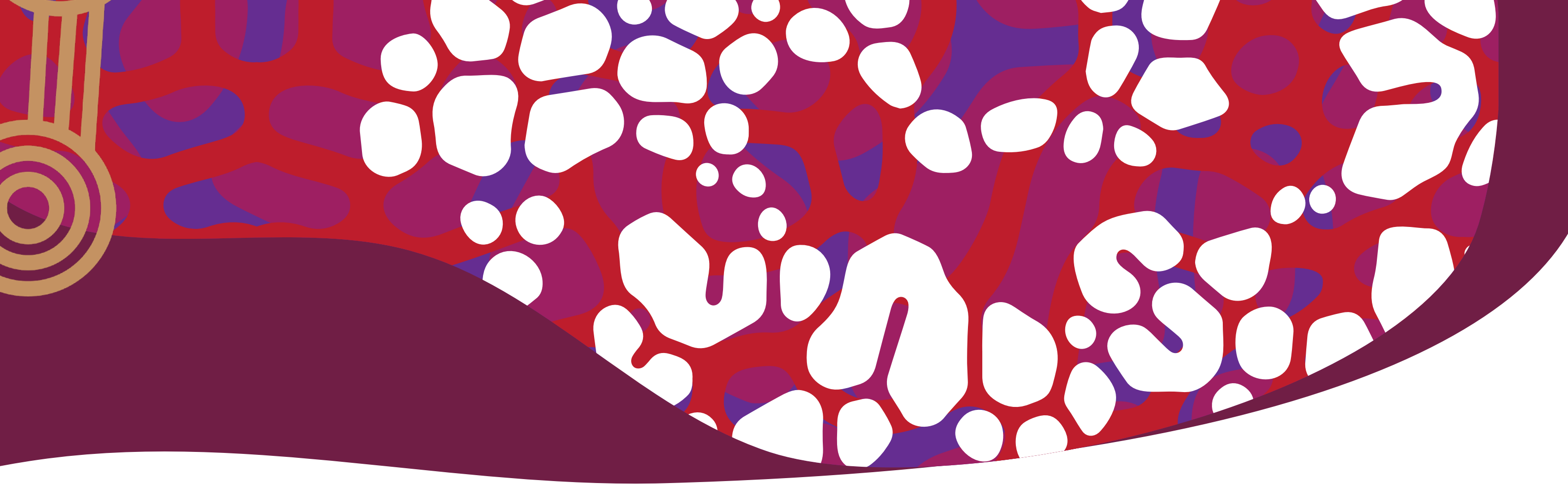

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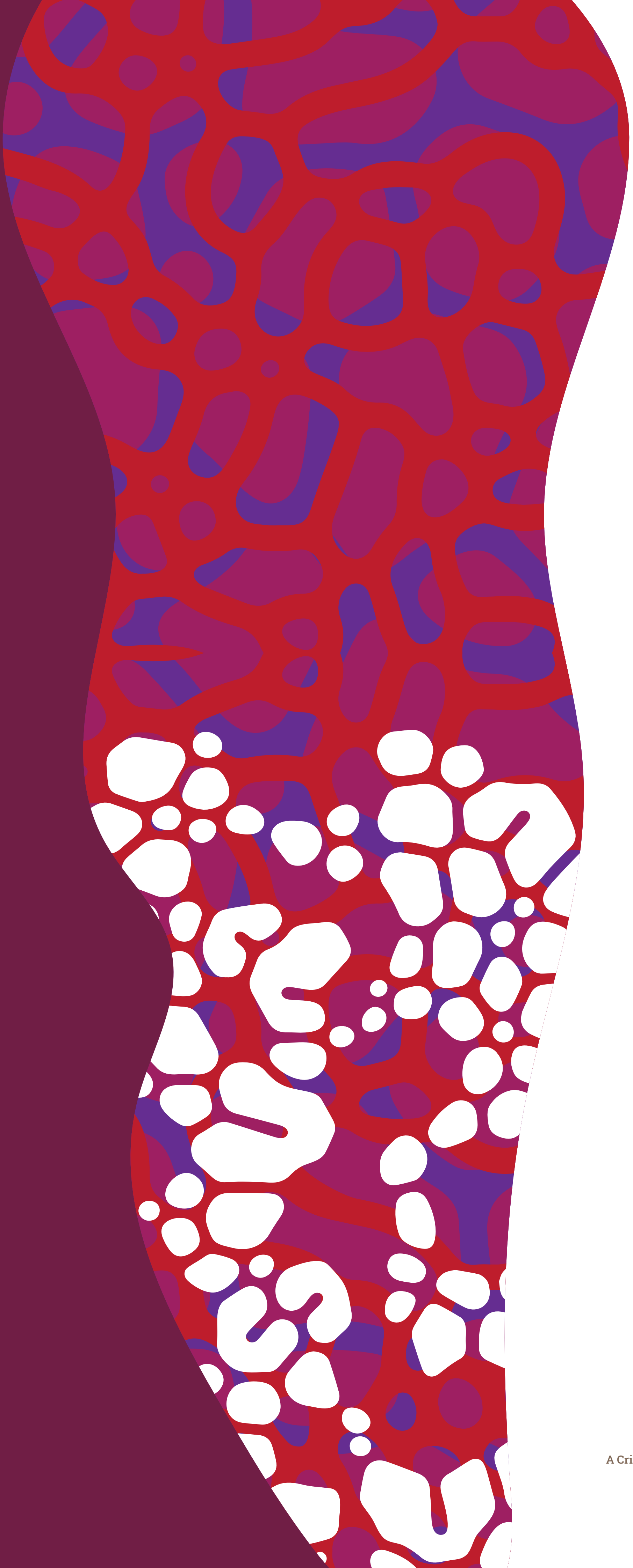

LOWITJA INSTITUTE

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ABOUT LOWITJA INSTITUTE

Lowitja Institute is Australia's only national Aboriginal and Torres Strait Islander community controlled health research institute named in honour of its co-patron, the late Dr Lowitja O'Donoghue AC CBE DSG. It is an Aboriginal and Torres Strait Islander organisation working for the health and welling of Australia's First Peoples through high-impact quality research, knowledge exchange and by supporting a new generation of Aboriginal and Torres Strait Islander health researchers. Established in January 2010, Lowitja Institute operates on key principles of Aboriginal and Torres Strait Islander leadership, a broader understanding of health that incorporates wellbeing and the need for the work to have a clear and positive impact.

The history of Lowitja Institute dates back to 1997 when the first Cooperative Research Centre for Aboriginal and Tropical Health was established. Since then, Lowitja Institute and the CRC organisations have led a substantial reform agenda in Aboriginal and Torres Strait Islander health research by working with communities, researchers and policymakers, with Aboriginal and Torres Strait Islander people setting the agenda and driving the outcomes.