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Supporting recovery, healing and wellbeing with Aboriginal communities of the southeast coast of Australia: a practice-based study of an Aboriginal community-controlled health organisation's response to cumulative disasters

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Abstract

Background The recent crises of bushfires, floods, and the COVID-19 pandemic on the southeast coast of Australia were unprecedented in their extent and intensity. Few studies have investigated responses to cumulative disasters in First Nations communities, despite acknowledgement that these crises disproportionately impact First Nations people. This study was conducted by Aboriginal and non-Aboriginal researchers in partnership with Waminda, South Coast Women's Health and Wellbeing Aboriginal Corporation, an Aboriginal Community Controlled Health Organisation (ACCHO). It investigated the collective experiences of people affected by cumulative disasters to identify the practices that support healing, and recovery for Aboriginal communities. The study addresses a knowledge gap of how Waminda, designs, manages and delivers responses to address complex health and social issues in the context of cumulative disasters.

Methods Underpinned by practice theory this study employed Indigenous-informed, narrative inquiry. Culturally-appropriate, multiple interpretive methods were used to collect data including: observations; yarns with Aboriginal community members, yarns with Waminda practitioners, management and board members; interviews-to-the-double, visual images and documentation. The data were collated and analysed using the phases of reflexive thematic analysis.

Results The paper articulates a suite of culturally safe and place-based practices that enhance social, emotional and spiritual well-being following cumulative disasters. These practice bundles include: adopting a Country-centred conception of local communities; being community-led; viewing care as a collective, relational, sociomaterial

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accomplishment and having fluid boundaries. These practice bundles 'hang together' through organising practices including the Waminda Model of Care, staff wellbeing framework and emergency management plan which orient action and manage risks. The paper demonstrates the need for disaster responses to be community-led and culturally situated. ACCHOs are shown to play a crucial role, and their local responses to immediate community needs are grounded in contextual knowledge and use existing resources rather than relying on mainstream system-wide interventions.

Conclusions The paper suggests crafting responses that focus on assisting communities (re)gain their sense of belonging, hope for the future, control over their lives and their capacities to care for and to be cared for by Country, are key to both enhancing healing, health and well-being and harnessing the strengths of communities.

Keywords Social and emotional well-being, Disasters, Covid-19, Aboriginal community-controlled health organisations, Cultural safety, Practice theory, Community action, Disaster relief planning, Indigenous health service, Personal narratives

Introduction

The recent climate-related crises of bushfires, floods, and the COVID-19 pandemic on the southeast coast of Australia were unprecedented in their extent and intensity. The 2019–2020 bushfires burnt 5.4 million hectares and killed an estimated 800 million animals [1, 2]. Much of the National Parks in the region were burnt. Plants, birds, animals, insects, and people were killed, and habitats, homes and infrastructure destroyed in rural and regional communities. These communities were in the early stages of bushfire response and recovery when floods, the COVID-19 pandemic and restrictions on movement hit.

Few studies have investigated responses to cumulative disasters in Aboriginal and Torres Strait Islander communities, despite acknowledgement that these crises disproportionately impact Aboriginal people as residents, as communities and as traditional custodians of Country [3]. The roles of Aboriginal communities in disaster planning, response and recovery have previously been overlooked [3, 4].

Accordingly, in this study, an interdisciplinary team of Aboriginal and non-Aboriginal researchers investigate the collective stories of people affected by cumulative disasters to identify the practices they experienced as helpful in healing, health and wellbeing for Aboriginal communities and Country.

The research is conducted in partnership with Waminda, South Coast Women's Health and Wellbeing Aboriginal Corporation. Waminda is a women-led Aboriginal Community Controlled Health Organisation which raises the health, well-being and spiritual status of Aboriginal and Torres Strait Islander women and their families in Southeast New South Wales, Australia on Yuin Country. For 39 years Waminda has been providing culturally safe and holistic services within the Shoalhaven region and outreach services from Wollongong to Wallaga Lake. Waminda offers the opportunity to belong and receive quality health and well-being support using a tailored, strength-based approach [5]. Waminda is recognised in Australia and internationally as a centre of excellence for Aboriginal and Torres Strait Islander Health and as a leader in ensuring culture is the central focus in enhancing social, spiritual, and emotional well-being [6].

This study addresses a knowledge gap of how Waminda, designs, manages and delivers responses to address complex health and social issues in the context of cumulative disasters. It demonstrates the need for disaster responses to be community-led and culturally situated. ACCHOs are shown to play a crucial role, and their local responses to immediate community needs are grounded in contextual knowledge and use existing resources rather than relying on mainstream system-wide interventions.

This paper articulates culturally-safe, place-based practices that assist communities (re)gain their sense of belonging, hope for the future, control over their lives and their capacities to care for and to be cared for by Country. These are key indicators of health, well-being, and inclusive communities [7] and thereby, central to enhancing healing and recovery.

Specifically, the paper addresses the following research question. What do the collective narratives of Aboriginal people affected by cumulative disasters tell us about the practices that support social and emotional well-being, healing, and recovery?

To achieve these aims we adopt Gee and colleagues' [8] p 0.55 definition of social and emotional well-being (SEWB) as a 'multidimensional concept of health that includes mental health, but which also encompasses domains of health and well-being such as connection to land or 'country', culture, spirituality, ancestry, family, and community'. The importance of the social, cultural, historical, and political determinants in shaping Aboriginal and Torres Strait Islander SEWB [9] is foregrounded in this paper.

This paper recognises that naming First Nations people is complex and varied. Aboriginal peoples is a broad term for the custodians of the lands within which this research

was conducted. The term Aboriginal peoples and/or communities is used in this context. Aboriginal and Torres Strait Islander peoples is also used when referring to Australian First Nations peoples. First Nations peoples encompass the diversity of Aboriginal and Torres Strait Islander cultures and identities and is also used in an international context. Before invasion there was no collective term for the diverse cultural and language groups of this Country [10].

Taking guidance from Waminda, and the research participants, Country is capitalised in this study as it is not only a common noun but also a proper noun. As discussed by Rose [11] p. 7) 'people talk about Country in the same way that they would talk about a person: they speak to Country, sing to Country, visit Country, worry about Country, feel sorry for Country, and long for Country. People say that Country knows, hears, smells, takes notice, cares, and is sorry or happy. Country is a living entity with a yesterday, today, and tomorrow, with a consciousness and a will toward life'.

Before discussing our research methods, analysis of the data and findings, we present a review of the literature focused on the question- What is the evidence about practices that support or hinder healing post cumulative disasters for First Nations' communities and the environments to which they belong? We review, in the context of colonisation, the impacts of cumulative disaster on First Nations communities, the contributions of First Nations knowledges to disaster management and the roles of ACCHOs in disaster risk reduction, response, recovery and mitigating cumulative traumas.

Cumulative disasters and First Nations communities

The cumulative disasters experienced over recent years have posed a threat to Aboriginal heritage and cultural practices creating challenges for community recovery [12]. Cumulative disasters contribute to a reduction in economic and social resources and a depletion of community resilience which, according to Anderson [13], is detrimental to collective SEWB. Further, the increase in social disadvantage can result in a deterioration of relational supports, consequently impacting mental and emotional health [14, 15]. First Nations peoples have expressed grief and loss over disasters' impact on Country [14], grieving for both human and non-human kin [16]. Ballard and colleagues' [14] study found a continuation of suffering in community, in relation to the overlapping losses and the damage Country continues to experience.

Since colonisation, First Nations peoples in Australia have experienced a loss of cultural, social, spiritual, and political rights, been dispossessed of their Country, and denied their identities [17]. The ongoing impacts of colonisation have forced many First Nations peoples to the margins, with the consequence of being amongst the most at-risk populations for poor health and well-being outcomes anywhere in the world [18]. As Williamson and colleagues [16] argue, this situation has also resulted in Aboriginal and Torres Strait Islander peoples having extensive experience of the impacts of trauma and, thereby, much to teach regarding resilience, resistance, recovery and strengths in relation to climate-related crises.

Relatedly, localised First Nations knowledges are significant in disaster risk reduction, response, and recovery, with mutual collaboration amongst community identified as a key practice in responding to disasters [19]. Ali and colleagues [18] argue approaches must be locally led by First Nations peoples using community development principles and situated on Country. However, instead of First Nations knowledges being utilised, climate-related disasters have compounded First Nations people's experiences of marginalisation [20]. Rawson's [21] study situated in Aotearoa/New Zealand shows that seeking assistance from health services or emergency response agencies is often problematic for First Nations peoples due to institutional racism, discrimination and dealing with the 'system' [21] p. 84. Williamson and colleagues [22] concur, arguing that without specific attention to the structural issues that perpetuate racism First Nations peoples will continue to be marginalised and excluded from disaster risk reduction, response, and recovery. There is a need to recognise the importance of self-determination in disaster response and recovery, cease the continued marginalisation of First Nations' voices and work collaboratively to bring their voices to the centre of decision-making [22]. For example, caring for Country is an intimate cultural responsibility for First Nations people [18], making up the human and non-human networks of kinship connections [4]. This care has been found to be beneficial to First Nations people's SEWB [23] as healing through spiritual and cultural practices is tied to Country [3]. The view of land as spiritual and interconnected highlights the significance of First Nations peoples' decisions to remain on Country despite experiencing consecutive disasters [22].

Accordingly, Weir and colleagues [24] argue that Country must be considered the priority in risk reduction, response, and protection as such an approach will also ensure the protection of human life and property as they are inherently connected to Country. While disaster risk reduction specifically associated with bushfires should be a focal point for risk management [24], there are risks to First Nations people when sharing cultural knowledge in relation to caring for Country. Fire management expertise as it relates to cultural burning is an example. This cultural practice is often perceived by non-Indigenous

stakeholders as purely fire management rather than directly related to care of Country [3].

First Nations people's relationship with Country is political in colonised lands such as Australia [22]. This politics incorporates the legal rights over land and the importance of Country, shaping First Nations people's cultural and social lives. Though laws in Australia have changed to enable the management of some areas of Country, most First Nations peoples have been consigned to the margins in managing their homelands [16]. First Nations peoples are often excluded from decision-making, with regulatory bodies focussing on caring for townships over Country [25].

Health services responses: the role of ACCHOs

ACCHOs are sites where Aboriginal people are centrally involved in decision-making as they are governed by a community-member board that primarily employs Aboriginal staff [26]. In Australia, ACCHOs are situated in communities providing holistic primary health care to their Aboriginal communities [26]. Disaster management and recovery literature demonstrates ACCHOs are central in enabling localised, timely responses to disasters as they possess local knowledge to provide culturally safe approaches to disaster management in their communities [26]. Cullen and colleagues [27] assert partnering with community is key to identifying firstly, what is needed, and secondly, the ability to respond to those needs. For example, during disaster management ACCHOs have led responses to basic needs such as access to food security, acquiring stable housing and supporting SEWB [26].

In the initial phases of disaster management, Hadlos and colleagues [19] review of the literature found ACCHO's responses utilised the resources and efforts within community with minimal reliance on external services. McCalman and colleagues [26] study found the community valued the nimble and holistic responses of ACCHOs to the COVID 19 pandemic and that this responsiveness reduced health and well-being risks to individuals and communities alike. Importantly, Williamson [3] claims ACCHO's were not established or funded to account for disaster management and these additional responsibilities have made agency resource constraints visible.

Despite evidence of the impact disasters have on humans and non-human kin the authors could find few studies of consecutive disasters within First Nations' communities [28]. Further, the authors could find no literature exploring the *practices* that support holistic well-being, healing, and recovery for First Nations peoples from cumulative disasters. Although, practice theory has informed and been informed by First Nations research in such areas as: racism in Finland and Australia [29] financial education in Canada [30] and Aboriginal and Torres Strait Islander young people and learning [31] the authors could find no literature providing a First Nation's lens on practice theory in relation to disasters. Accordingly, this study uses an Indigenous-informed approach to practice theory to investigate responses that support Aboriginal communities to heal and articulates the connections between practices enacted by Waminda staff, participants, and communities to enhance mental, physical, emotional, social, and spiritual well-being.

Research sites, methodology and methods

This study focuses specifically on Waminda's SEWB practices with service recipients, staff, and their communities in the context of the 2019–2020 bushfires, floods, and the COVID-19 pandemic. The SEWB team works across services and programs, collaborating to support people's decision-making, healthcare needs, cultural knowledges, and cultural safety. The SEWB programs assist clients in having access to the specialist physical and psychological care they need in a timely manner, and with a focus on flexible service delivery. This context of cumulative disasters demanded an expansion of Waminda's service footprint to include Aboriginal communities in towns and villages along 300 km of the south coast. Accordingly, this study, includes as research participants Waminda staff, service recipients and community members from the distributed Aboriginal communities of the Illawarra, Shoalhaven and far south-coast regions impacted by the cumulative disasters.

This study was approved by the Aboriginal Health and Medical Research Council Human Research Ethics Committee (no. 1779/21) and the Ethics Committee of The University of Wollongong & ISLHD Health and Medical Human Research Ethics Committee (no. 2021/ETH00110). No ethical issues were identified in the study. Eleven authors identify as female and one as male with backgrounds in social work, public health, nursing, Aboriginal and Torres Strait Islander healthcare and occupational therapy. This interdisciplinary team is well suited to conduct the study as most have extensive experience in collaborative research using qualitative methods, four team members have First Nations cultural knowledges, nine have PhDs and five live in the communities directly impacted by the bushfires and floods. The lead author has expertise in applying practice theory to research and guided the conceptual framework of the study.

Methodology

Underpinned by practice theory [32] this Indigenous-informed, narrative inquiry [33] was co-designed with Waminda. Healthcare settings and organisations are turning to practice theory to understand health services responses and service user experience [32]. Reviews

of mental health and psychological interventions have emphasised the need for practice-based evidence from everyday clinical and organisational settings to complement the evidence-base obtained from randomised controlled trials [34].

In practice theory, the primary unit of analysis is practice, described by Schatzki [35] as the complex interactions of sayings, doings and relatings between people, other beings, and material artefacts. Accordingly, a practice-based approach for this study focuses on the situated, embodied, spatially and temporally extended ways that staff and community members involved with Waminda work to support recovery in local communities amid environmental and public health crises. This approach involves working with Waminda and their communities to identify from their collective narratives [36] the practices, relations and the spiritual and material arrangements that enhance recovery, well-being and healing for people, kin, communities, sea, and land [37].

The researchers' community-engaged, participatory standpoint aims to learn with and from Waminda and the communities they serve. Indigenous-informed narrative inquiry is a methodology that is inclusive of multiple stakeholders and involves individual and collective exploration of experiences and critical reflection on practices [33]. Such an approach is particularly suited to this project as it stresses the importance of context and culture. Story and the act of storytelling are important in many First Nations people's communities [38] and well suited to research with Waminda, which involves local Aboriginal communities as participants in the study. The methodology emphasises oral communication, relationship and co-creation between researchers and participants [38]. Storytelling is an ideal method for integrating the role of other-than-human elements such as Country, animals, water, wind and fire into data collection and analysis [39].

Participant recruitment and selection

Purposive sampling was used to recruit participants who were: (1) Waminda staff, management, or board members (2) South coast Aboriginal community members over the age of 18 years who were impacted by the 2019–2020 bushfires, floods, and the COVID-19 pandemic. All participants are de-identified and pseudonyms are used. Aboriginal community members, Waminda staff, management and board members were recruited via email, flyers, announcements at meetings and gatherings at Waminda between May 2021 and April 2022. The Participant Information Sheets (PIS) were made available, the researchers talked through the PIS and answered any questions that potential participants had. Informed written consent was obtained from participants prior to data collection.

Data collection methods

Capturing practice requires a toolkit approach, asserts Nicolini [40]. Accordingly, culturally-appropriate, multiple interpretive data collection methods were utilised, including:

- Written ethnographic accounts of *observations* of a range of Waminda programs, workshops, and everyday interactions (approximately 14 h of observations) [See supplementary file A for observation protocol].
- Transcripts of *yarns* with 38 Aboriginal people (Female = 33, Male = 5, Age = 25yrs-78yrs) living in 7 communities impacted by cumulative disasters. Our conversational yarning approach uses four types of yarning, adapted from Bessarab and Ng'andu [41] - the social yarn, the research yarn, the healing yarn, and the collaborative yarn. Yarns ranged from 37 to 150 min [See supplementary file B for Yarn guide].
- Transcripts of *yarns* conducted with 32 Waminda practitioners, managers, and board members (Female = 30, Male = 2, Age = 24yrs- 61yrs). Yarns ranged from 32 to 143 min [See supplementary file C for yarn interview guide].
- Transcripts of *interviews-to-the double* with 6 female practitioners from Waminda's SEWB programs. The interview-to-the-double [42] is a technique that asks interviewees to imagine they have a double (the interviewer) who will replace them in their job. The interviewee is then asked to provide the necessary detailed instructions which will ensure that the 'double;' will not be unmasked. This technique is useful for verbally eliciting and articulating practice in a situated context when direct observation is impossible or undesirable. They ranged from 50 to 61 min. [See supplementary file D for interview-to-the double guide].
- Transcripts of two *collaborative yarns* that involved SEWB staff, board members, Waminda managers and research team members, sense-making, co-analysing and reflexively discussing early research findings to explain or make visible practices and new understandings [41].
- Translation of early analysis of the data into *visual images* by research participants.
- Documentation and artefacts including Waminda's model of care, Balaang Healing framework, staff wellbeing framework, emergency management plans, Annual Reports, and photographs of the bushfire and COVID responses.

SC, LK, MM and SF collected the data and participants identified themselves to these four authors. Two of these researchers knew some of the research participants prior

to conducting the research. All yarns and interviews-to-the double were audio recorded and professionally transcribed.

Data analysis

To identify the *practices* that support SEWB, healing and recovery in the narratives of Waminda staff and community members, we 'zoomed in' on the *doings*, *sayings*, *relatings*, *spiritual and material arrangements* discussed in the data. We also 'zoomed out' to the broader organisational, social, and political context and arrangements [43]. The data were deidentified prior to analysis. The data were collated and analysed using the phases of reflexive thematic analysis outlined by Braun & Clarke [44] by LK, MM, SC and RE. The researchers initially: (1) familiarised themselves with the data; (2) coded the data using words from the texts; (3) inductively developed more 'abstract' codes to develop the themes; (4) reviewed the themes; and (5) refined and named the themes [45]. This early identification and analysis of themes and practices was corroborated in sense-making, collaborative yarns conducted with managers, board members and practitioners. We incorporated member checking, co-analysis, and validation by inviting research participants to review and comment on their transcripts and our early interpretations of the data [46].

Findings

In this section, we analyse the practices enacted by Waminda that were co-emergent and co-constitutive of their responses to the environmental and public health crises. The data analysis identified five dominant practice bundles [35] in the Waminda responses. Drawing on Schatzki [35] practice bundles refer to sets of practices and spiritual and material arrangements that work together and are interconnected in more or less dense and persistent ways [47]. The practices are not discrete, they are entangled, bundled together such that each practice bundle is comprised of multiple practices. These practice bundles and some of the practices that make them up are:

(1) Adopting a country-centred conception of local communities.

- Connecting to Country spiritually, physically, affectively, and emotionally.
- Complex view of bushfire as a resource for healing.
- Caring for Country after the bushfires- a practice for healing.

(2) Community-led

- Deep listening.
- Response-ability.
- Networking.

(3) Fluidity of boundaries.

- Willingness to change roles and transform spaces.
- Expanding boundaries and the Waminda footprint.

(4) Caring: a sophisticated, collective, socio-material accomplishment.

- Sociomateriality of care practices.
- Hanging in there, staying with the struggle.
- Enabling women to be active in their own care.

(5) Organising practices: orientating situated actions and managing risks.

- Enacting the Model of Care and emergency management plan.
- Co-ordinating and enabling the practice bundles to 'hang' together.

These practice bundles work together to form a texture of practices that harness the strengths of Aboriginal communities in disaster responses and recovery. The practice bundles and the practices which constitute them were translated into visual images (Fig. 1) by some research participants, led by Aunty Lorraine Brown and Aunty Narelle Thomas, renowned artists from the Coomaditchie United Aboriginal Corporation. Figure 1 beautifully shows how these practice bundles and themes are entangled, overlap and not easily separable.

Aunty Lorraine Brown and Aunty Narelle Thomas explain:

> *The flower shapes, handprints and footprints represent community and the strength that brings community together in times of tragedies, loss, destruction and a fight against sickness [COVID pandemic], fires and floods. People working together to console, to care, to listen, to repair and to find the overpowering strength to continue on. The lines connect these communities together- the bold colours reflect- east coast saltwater people, communities and Country.*

Fig. 1 Strengths of our communities- Lorraine Brown & Narelle Thomas

Adopting a country-centred conception of local communities

Waminda adopts a Country-centred conception of community connections and local communities that encompass the land, other-than-humans, humans, and the entangled relations amongst them. This ontological standpoint is threaded through all the practice bundles discussed in this paper. This inseparability of Country and community means practices such as connecting to Country, caring for Country after the bushfires and adopting a complex view of bushfire are key resources for healing body, mind, spirit, and heart's pain.

Connecting to country spiritually, physically, affectively, and emotionally

The entanglement of personal and Country well-being is evident in Dawn's, an Aboriginal health practitioner, description of travelling down to Mogo after the fires.

> *That trip down the coast was the saddest trip that I've ever had in all my life. And I've been travelling down there since I was a kid. To see that much of the bush burned out. It was so so sad. And when I came to Mogo and seen the way it was burned and how it was affected, that first time I really cried. And to go down there now, it's so refreshing. I really love the drive now because everything's regenerating and the trees are all growing so it makes me feel good again, so good.*

The centrality of connecting to Country for healing, recovery and holistic well-being is reinforced by Aunty Margaret, an Elder and Waminda board member, who comments:

> *People are very connected to the ocean. I think they're not going to fully recover until COVID goes and it stops disrupting everything because they really haven't been able to recover because COVID came just after the bushfires. But their connection to the water and that, they get … how could you say it? … like a sense of belonging, when they go to the water to collect their food and to fish and to do all of that stuff. That's all a normal part of our culture, to be connected to the water and live from the water.*

Aunty Margaret's words demonstrate the centrality of practices involving the ocean for enhancing well-being after the bushfires and how COVID-19 movement restrictions made such gatherings and intermingling with the sea impossible for some communities. Simultaneously, for those communities who were able to continue to be nourished and sustained by the ocean, these cultural practices involving water were key to mitigating the isolation, uncertainties and restrictions that were part of the COVID-19 pandemic.

Complex view of bushfire as a resource for healing

Manaaki, a case worker, describing his experience of the bushfires, illustrates the tensions, complexities and nuanced view of fire underpinning the Waminda response:

> *It was like the apocalypse. It was confronting living in bush smoke every day. Having, you know, ashes landing in your backyard, just awake all night with the worry of maybe the house might get burnt down, you know, and watering the roof. I think seeing injured and dead animals from it too was pretty hectic… Yeah, I think also understanding the necessary sort of process of it [fire] for healing Country… how fire relates to birthing and renewal, sort of like that phoenix concept… The germinator of seeds in Country here. Yeah, it was like the whole country was getting smoked and sort of like a ceremonial state but the level it went to was not good for the trees and not good for Country. There is a lot of healing that needs to come about. Yeah, a lot of animals were lost, a lot of homes were lost. Yeah, I sort of balance it with – I balance the grief and loss with that philosophy of the renewal of life.*

This stance of holding in tension the terrible, regenerative, and ceremonial potentials of fire is embodied in Waminda *practising smoking ceremonies* as a means of coming together for healing in the midst of their bushfire response. Sharmaine, a manager, and member of Waminda's cultural committee explains.

> *So, when we came back from the bushfires and come back into work, and there was that feeling of loss, and there was that feeling of grief … So, yeah, we thought, "Well, what do we need to do? We need to come together. We need to come to a place where that healing, we need that cleansing, we need a smoking". So, that's where the smoking actually come from, and that's what the cultural committee agrees to have with all staff [both Aboriginal and non-Aboriginal], because it affected all staff.*

Caring for country after the bushfires- a practice for healing

A common practice evident in community yarns is the healing power of caring for Country and learning to care for Country after the bushfires. Meryn's, (community member) narrative is representative:

> *So, we did wildlife care and the wild feeds. Also, people were putting bread out, and so we were going around collecting the bread, because it's not actually good for them. We put fruit out instead. So, we did that around Watos with the boys, with the guidance of Maria and Jamie down the road telling us… And we got educated … on our walk we'd take a little thing of seeds, and you sprinkle it on the front yards of everyone down where it was all black, for the kangaroos and that. I think it's made all of us respect the land we live on and what it gives us. Not just our house, but everything around us, to watching it being black to seeing how quick it grew. Like, the green was, it come back really quickly, didn't it? The kids learnt so much about the animals and feeding them, putting water out, which they still do now. They all made the bird feeders, and how you can't paint them because you don't want them to get sick from the paint… it's all got to be oiled. We learnt all that from other Elders teaching us. People sharing their knowledge. As young people, you don't really know… I never, ever looked at the ground, the trees, how beautiful everything was, until that fire.*

Here Meryn describes how this small community came together to care for the land and kin after Country was devastated by the fires. Neighbours, both Aboriginal and non-Aboriginal, who hadn't had much contact prior to the fire were guided by those with experience in local wildlife and land care, enabling this young Aboriginal family to learn and to begin to recover together. Meryn goes on to describe how these practices were critical to the recovery, health, and well-being of her children:

> *Looking after Country feeds us and the kids. The green trees and how healthy it is, only helps their health. Without that, kids like… how nasty and dark and gloomy and yuck the ground were for them. They wanted to see how… and they went down and said, oh look, it's growing, Mum, there's flowers! They just started to see… it's all black, and then there's one green plant and then more… and they want to take photos of that. And we are also so grateful to still see there's kangaroos bouncing around again.*

Perhaps the COVID-19 movement restrictions allowed these children and their community to see and notice these first green shoots, the first flowers. Perhaps if they were able to travel to school and work each day, this learning and care would not have unfolded. The small shoots of renewal may have gone unnoticed as they require slow time, close looking, touching, and smelling, an intense local attention to be seen.

Zooming out to broader context: discounting, denying and not valuing Aboriginal ways of knowing, being and doing

This bundle of practices that shape and are shaped by Waminda's Country-centred conception of local communities challenge dominant fire risk reduction, response, and recovery discourses which position 'the bush' and its inhabitants at the bottom of the hierarchy for protection after human life and property.

In a collaborative yarn Aleesha and Sharmaine, managers, discuss the discounting of Aboriginal ways of knowing, being and doing embedded in such discourse.

> *Aleesha: I think the other part of the bushfire was the fact, the thing that made it complex, well what hurt more is that as Aboriginal people, we've been ignored for that long, we wouldn't be in the place that we are in if it wasn't for the impact of colonisation, being ignored and not listened to our traditional practices from day dot… So, when I think of the fires, I think of the ignorance. I think of how we've got practices that have worked for hundreds of thousands of years, but they just get pushed aside, and then we're watching our Country, all this devastation and all that harm, because we're ignored.*
>
> *Sharmaine: And I think too, it goes back to, it's always at the cost of something, when white people don't listen, and it's always at the cost of our sufferings, our environment, our Country, our land, us as people.*

Within this colonised context, the data illustrates how this bundle of practices that enact a Country-centred view of local communities contributes to people's capacity to care for and be cared by Country and strengthens their sense of belonging to their communities. Such practices, thereby, create conditions of possibility for healing and enhancing well-being for children, adults, communities, and Country.

Community-led

Being led by community, listening to local people, recognising the importance of local knowledge, and trusting that the community knows what is required and what matters most to them is a dominant practice bundle evident in the data.

The following quote by Tanya, a case worker, represents this orientation to responding to disasters, which was reiterated by almost all of the Waminda staff participants.

> *And the work we do is driven by, it's led by community. And I think that's a really strong message… We are led by community and the need comes from community and that leads us. So those decisions were made by community, and we just acted upon the needs of the community.*

Being community-led requires practices different from those generally enacted by emergency services, large non-government organisations and the government. Below we discuss three of the practices that make up this practice bundle: deep listening, response-ability, and networking, that the data analysis suggests work together to enable a community-led response.

Deep listening

Deep listening is central to being community-led and a *key relational practice* in the narratives. John, a member of the maintenance crew, turned first responder in the bushfires explains:

> *I think if anyone is looking to put themselves in a position to help anyone, the most important thing is to just sit there and listen. Leave your phone in the car. Grab a bit of pen and paper, then write it all down and feel that - be connected to it. Listen to the pain. You shouldn't say anything. If you're going to listen, you should only probably talk when asked… We could have sat in each community for hours on end. You've just got to get down there and have an understanding of what they was going through and the only way to do that is sit front and centre and to listen.*

John's comments encompass deep listening, listening that is respectful, that is felt and does not involve filling the silence but pays quiet attention to what is both said and not said.

Deep listening, as the foundation to being able to be community-led in the midst of disaster responses, is evident in Bridget's, a mental health practitioner's advice:

> *Listen, listen to community. No service has all the answers for community, like community, has their own answers. They will know what's needed. They're like the experts in their own lives and their own stories. Problems can be incurred when decisions about what is needed, is out of sync with what's actually being asked for.*

The practice of deep listening, of sitting and holding people's suffering at the centre of attention, is crucial but not sufficient if responses are to be community-led and 'in-sync' with what is needed. Determining how to quickly cobble together the resources to deliver what is needed demands what Donna Haraway [48] describes as response-ability.

Response-ability

Each day as the climate-related crises unfolded, Waminda had to cultivate the capacity to respond and engage with the unexpected. Being response-able is central to effective responses, as it answers the trust of the held-out hand, demonstrates listening and remembering and, thereby, enables community-led responses. John explains:

> *If you're going to do something about it or your actions, you know, there's no point in saying "oh yeah I'm gunna", get it, get it down there. Get it off the trucks. I think that's what it was all about, just being present in the moment and listening and relaying that back… So, I'd ring up and say, "June we need this" and by the time we' d get back that night we were able to access it. We were able to go purchase it. Jade and my old Brett, our finance team just had everything sorted for us. It was a collective. It wasn't just us but the team, everyone to help and the whole organisation involved, community too. Waminda listened and Waminda actioned it.*

Here response-ability is a collective knowing and doing that requires an ecology of practices to be enacted just in time to ensure communities can access the supplies, the medical attention, and the people to listen to their stories. Indeed, all the arrangements they need to sustain themselves and live with the anxiety, stress, and grief that disasters provoke. Continually cultivating

response-ability ensured Waminda could meet the obligations and responsibilities that 'turning up' entails.

Networking

Building, extending, maintaining, and using networks across the southeast coast is a prerequisite for being community-led. The networks Waminda relied upon during the environmental and public health crises were not a contact list stored on a computer, but multigenerational webs, nodes and pathways tied together with sticky threads of connection.

Karena, a well-being support practitioner, and member of the cultural committee, explains:

> *We identified who the key people were in the communities who we could reach out to- to speak to them about what support the community may need that we could provide and ensure particularly for that far-south coast that it got to everyone and knowing that that's our mob as well. We needed to be there to be able to support them.*

Waminda used these key contacts and relationships as nodes, and they in turn distributed what was needed throughout their communities, creating an interlaced web in which communication travelled along many lines multi-directionally. Aunty Phyliss, a community member and Elder, described how the process worked during the COVID pandemic.

> *We got really good hampers from Waminda, which was really essential, and Makala would drop them all off for us… what she brought up really went around a wider community… community of people that missed out, to the people in lockdown, families with COVID. Yep, we were like drop-off point for a whole network around here, Albion Park, Unanderra, Dapto, Shellharbour.…*

But these networks are hard won and not easy. Sharmaine explains:

> *I'll be honest, that can be challenging for us too at times. I mean, when I think about the bushfires, that was really hard, making sure that we're having contact with those, certain contacts in community, because not all community get along, so therefore, we've got to make sure that we're actually talking to everyone so that we're not leaving anyone out. A mainstream service, they can't do that, they can't guide that. It's hard enough for us to do that, let alone a mainstream service.*

This bundle of practices that we call 'community-led' can be traced out to the institutional context within which Waminda's responses emerged.

Zooming out to broader context: lack of institutional listening and responsiveness

Amid the bushfires and Covid-19, almost all Aboriginal community members report an absence of listening by those with decision-making power, including some health department officials and emergency services personnel and politicians. Community were denied not only a voice but also an audience. Lora, maintenance crew turned first responder, explains:

> *They never lost their voice. From Batemans Bay all the way down to the Inlet no one was really listening apart from I think Waminda and a few other people. They were asking you know but like our government went down, it was a big thing with Scomo [nickname of former prime minister], but it was more for the 6 o'clock news.*

Yasmin, a young single mother with two children with disabilities, describes what happened when she got a text letting her know that she and her children had contracted COVID:

> *I got a text message to say that, I was positive. So, I rang them [the state health service] but that was it… I thought about it, like what happens if I need to call an ambulance right now? What do I do? What if they need to take me to hospital? What do I do? I've got two kids inside… they're both positive for COVID, we all had it, like what do you do? They didn't get back to me, no one listened… There was no, they didn't even send me phone numbers to say if you need help with food, nothing. There was nothing.*

The lack of responsiveness evident in Yasmin's narrative was a common experience among research participants. Such a lack of response is dangerous, given the responsibility the state health services were accorded in providing information and guidance during the pandemic. A member of the Waminda executive, June, describes the struggles experienced trying to secure timely responses from the health system when COVID-19 first began spreading in the Aboriginal community.

> *Yesterday, there was a positive case in one of our clients. NSW Health just didn't know what to do about that. We rang them and said, "Well what's going to be our response? She's at home with her three-year-old, like what are you going to do? Who's going to ring her? "Oh yeah she's on the list". "When are you*

going to ring her?"... The day before we'd literally had 30 people on the Zoom, 30 big white bureaucrats talking about their response in the Aboriginal community, and they can't go out to one woman and a three-year-old and support her with what she's got to do and she's positive and sick. They are trying to work out what they're going to do while we're doing it and they're not listening.

It is clear from participants that while in principle primary and tertiary health services are funded to provide a service to all members of the community, in practice this was not occurring. Participants highlighted a lack of responsiveness to Aboriginal and Torres Strait Islander people in a way that meets their needs.

In this context where response-ability must be ongoing, not in the abstract but in practice, participants agreed it is difficult to overestimate the value of responses that are community-led and place local people and their knowledges at the centre of decision-making. Such practices contribute to people (re)gaining a sense of control over their life, hope for the future and ensure people experience recognition and representation.

Fluidity of boundaries

Engaging collaboratively, practising mutual respect, being response-able and privileging the expertise of the local community is also entangled with another practice bundle evident in the yarns and observations - deliberately blurring and creating fluid boundaries between workers, community members, board members and their work roles. Most workers identify as being of the community rather than simply providing services to or for the community.

Dianne, a manager, and member of the cultural committee, explains:

Because they're us and we're them. That's the difference. I think that's a big difference with Waminda. As a service, we never ever separate ourselves from community, because we are community.

Willingness to change roles and transform spaces

In responding to the bushfires Waminda's staff had to quickly change their work roles. June, a member of the executive team, explains:

We don't ever get people to do anything we wouldn't do ourselves. I deliberately, and all the executive too, we were doing trips as well just so that it wasn't like, "Okay. Well, good luck and let us know how you go when you get back." We were just packing boxes and doing all that stuff to say, "This is what our whole response has to be because it's sort of family".

The building that is usually home to the SEWB and case management team was transformed into a warehouse and packing space. The maintenance crew became first responders. Michelle, member of the Beehive team, describes how their roles and work were transformed, an experience echoed by the almost all Waminda staff participants:

I remember the day that we heard about how badly the Aboriginal communities had been affected, we made a plan. We got everybody doing something, running around collecting stuff, purchasing stuff, putting the boxes together, putting the meals together, getting vouchers to help support people, trying to source generators. And we sent our maintenance team out there with all those resources for people, there were clothes, there were tents, there were sleeping bags, there were things for people who'd lost their homes... And we were the first on the ground for that community [Mogo], and in fact, in some instances it was weeks after we'd made first contact and provided them with help and assistance, that they actually got a little bit of support or even saw anyone from any of the other mainstream services. We were in constant contact with the maintenance teams to see how they're going. We were constantly monitoring the fire situation, making sure our teams were safe.

Expanding boundaries and the Waminda footprint

This bushfire response required Waminda to expand its service footprint and boundaries quickly. Michelle's comment is representative of Waminda staff participants views:

Community, when push comes to shove, they'll absolutely, just respond. There's no question of whether you're overstepping your boundary, you know how AMSs [Aboriginal Medical Services] are supposed to only work from here to here, and the next AMS is responsible for this to this, there was none of that. There were people in need in community who weren't getting the help from mainstream services, and it was either us or no-one. There wasn't a question of whether or not we should. You just don't leave your kin to suffer.

Zooming out to broader context: exclusionary boundary-making practices

This expansion of boundaries occurred when some other ACCHOs directly impacted by the bushfire, could not meet the overwhelming and urgent needs of community. Further, many Aboriginal community members experienced mainstream services as hostile, discriminatory and unwilling to assist. Trevor, an Aboriginal community member in the Dalmeny yarn and volunteer at the evacuation and recovery centres, explains:

> *The first shift I did at Batemans Bay, I was sitting there watching black fellas come in, get their number, told to sit down, and wait. White fellas come in, get a number, push through, go, and talk to someone, here is your hotel. Then, and I'm shaking, I'm so angry about this, I overhear shit like "that family over there is Aboriginal so just watch them because they're from Mogo and they said they lost their house but Mogo's fine so they're just scamming". Because it was two or three days for them on their little system to catch up to say that Mogo had been hit, and so for days black fellas are coming in from Mogo and they're being ridiculed, they're being made out to be liars, they're being made out that they're ripping the system off and they're being sent away in shame with nothing.*

Restricting service responses to within the boundaries determined by an inaccurate data system unable to keep pace with the spread and impacts of the mega fires produced care-less, culturally unsafe, discriminatory responses that were threaded through with racist attitudes and practices.

Caring: a sophisticated, collective, sociomaterial accomplishment

Caring for humans and other-than-human kin is at the heart of healing in climate-related disasters and a crucial practice bundle evident in the data. At Waminda, care is not a transaction, a quality, or a dyadic relationship between the carer and those being cared for. It is *caring* as an ongoing, sophisticated, collective, sociomaterial accomplishment.

Bridget, a mental health practitioner comments:

> *There's that idea of collective care, which is culturally embedded and based on the very, if you like, vital and personal nature of the work, people are people. It's humanising, actually. It's a humanising way of providing care, as opposed to some of the mainstream approaches you could argue, would be more dehumanising in their approach.*

This type of caring, that contains the germs of partial healing even in the face of devastation and destruction, is made up of a texture of practices including taking anticipatory action, hanging in there, staying with the struggle and creating opportunities for women to look after their own bodies and get healthier and happier with the Waminda family. Perhaps the aspects of care practices that were most dominant in the data are the powerful role of sociomaterial arrangements and enabling women to be active in their own care.

Sociomateriality of care practices

Throughout the narratives and yarns, care practices concerning both the bushfires and COVID-19 involved lots of 'stuff'. Care was carried and enacted with/in generators, clear eyes, care-packs, bandages, food and drink, mobile phones, and social media. Natalie, an Aboriginal Health Worker, explains how she and three other young women from the palliative care team put together care packs for families during the COVID-19 lockdown, when the children were required to be home schooled:

> *So, this room was just lined up with boxes. There was like 20 or 30 boxes going out every few days to different families and we were listening to the families about what they needed as, depending on how many kids they had and the ages and how many adults were in the house, making sure that they had things appropriate in the box suitable for that family. So, they weren't all just the same, each box was sort of tailored for the family... We done the food as well, craft and the activity packs for kids, basically having things set up at home because of the lockdown... Then the maintenance team would come and pick them up or anyone that was able to chuck them in their car would come pick them up from here and then drop them off or we'd put them in the big bus and then drive around and drop them off. And during that time as well we were still continuing the food hampers and all the supplies for the bushfires.*

Kerry, a counsellor elaborated:

> *We had people's names on the box, we wrapped it in gift paper with a ribbon. It definitely felt, it felt important for us, it was a genuine gesture. It wasn't a stock standard gesture.*

Here care *matters* in all senses of the word. Caring rests on understanding relationships as a response to another on their terms and in their specific circumstances.

Women active in their own care

The sociomateriality of care is also evident in the following quote from an interview-to-the-double with Bella, a diabetes educator. It reflects the everyday way in which Waminda practises care:

> *It's about the ladies wearing the CGM, the continuous glucose monitor, and so learning about their glycaemic control and their patterns even when they're asleep and the reasons why it might be high, and they can see in real time what their blood glucose levels are doing. So, it's not me saying oh, you can't eat that because… It's more self-determination, so they might go, oh wow, I just had some pasta for dinner and my sugars went up to 16 and they stayed up all night long; maybe pasta's not such a great option for me.*

The entanglement of technology with care practices was also used to promote bodily autonomy in the bushfire and COVID-19 crises, as Annie, a midwife explains:

> *I suppose from a clinical perspective, thinking about trying to provide clinical services within the main hub and then out in community when the fires and COVID are happening, it's pretty hard to navigate how to get past all the risk. We were able to provide telehealth services, facetime on phones and iPads and organising just over-the-phone advice. What I've seen is that it's given the women that we look after their body autonomy as well. So, we educate them about how to look after themselves and their bodies during pregnancies, get them to feel their babies, and get them to do their own checks at home when they think that they might be unwell and unable to come in.*

Zooming out to broader context: patriarchal, white colonial society

Waminda's care practices are enacted in the context of a patriarchal white-settler colony, its ongoing immigrations, and struggles over recognition for Aboriginal and Torres Strait Islander peoples. Mainstream service providers and government departments have and continue to cause harm to Aboriginal and Torres Strait Islander peoples. The service system often looks for a deficit, which in turn generates a deficit. This patriarchal, colonial deficit lens tends to regard Aboriginality and culture as a risk, entrenching more harm by casting what is a strength as a deficit.

The following extract from a collaborative yarn with Waminda staff analyses the practice of using iPads and Facetime to teach pregnant women how to monitor their bodies during the bushfires and the pandemic:

> *Luz: Working in the child protection space, there are that many women who were seen as not receiving antenatal care, because they were scared to go out during COVID, but then they came under the attention of child protection services, or even had their children removed as a result of not having antenatal care.*
> *Sharmaine: … and a big part of that, is because we're Waminda, and it's matriarchal. So that's a really big thing, women active in their own care, it's women's self-determination.*
> *Aleesha: And it goes back to sovereignty never ceded, and that includes our own personal bodies.*

In this context, caring creates affective relations that enhance a sense of control over one's body, hope for the future, and belonging to a community in which care matters. Such practices are, in the words of Sara, a community member from Ulladulla,

> *so helpful for mental health. That's the big thing – mental health… they work on how you feel about yourself and how you can connect with each other.*

Using organising practices to orientate situated actions and manage risks

In this section, we discuss the key organising practices, including Waminda's Model of Care (incorporates the Balaang Healing framework and the staff well-being framework), and the emergency management plan (for visual representations and details of these models and frameworks see Waminda, Annual report 2022–2023 [5] p. 6–8) that coordinate and enable the bundles of practices discussed in this paper to 'hang together' to form a holistic Waminda response, thereby, enhancing healing, recovery and wellbeing.

These organising practices, which have culture and the recognition of the impacts of colonisation sedimented throughout, were organically and dynamically integrated into the ways of doing, being and valuing during the environmental and public health crises. Tayla, an Aboriginal health worker's, comment is representative:

> *Everything we do talks to our Model of Care within Waminda. It's embedded. Waminda's Model of Care is embedded to me as Tayla, as Aboriginal health worker, as Infection Control Officer, as all my hats that I hold, Waminda's Model of Care is embedded.*

In Tayla's words, the Model of Care is embodied in her practice. A mental practitioner and leader of the SEWB team discussing their response to the bushfires and then COVID concurs:

> *Our way of being, of working collaboratively actually embodies the healing framework. Everything we've been doing was in line with the healing framework… But it wasn't like, any of us got out the healing framework and went off each bit and said somebody signs. It was this natural progression.*

In this way the Model of Care oriented Waminda's response to crises but was not used as a step-by-step guide that predetermined how to proceed.

June, in her role as emergency response coordinator in the bushfires, discusses the emergency management plan and the staff well-being framework:

> *We've had to have in place for accreditation, and just because it's good practice, that sort of emergency management plan, but you can never ever imagine using it. So, when it actually did happen there was some things that did just really click in from having to do that for all these years… So, my home became, like a little SES, because I had shit everywhere and everything all laid out on the table and everyone's phone numbers and everyone's contact details, their next of kin and the maps. The TV was going the whole time and the radio and the phone with alerts and then just hooking up trying to think who was affected by what. Just getting my head around really quickly with IT about contacting staff all at once through our text messages and stuff… So having that staff well-being framework and actually doing it, like making 130 calls four times a day.*

The relations between Waminda's organising models, frameworks and plans and the bundles of practices that made up the Waminda response to the crises are complex and interconnected. The Model of Care and the emergency management plan are best understood not as a pre-existing series of sequenced steps that prescribe practice but as conceptual, affective, and culturally-situated resources for action. Accordingly, the practice bundles articulated in this paper were not explicitly determined by Waminda's models and plans but in situ by local interactions with staff, communities, and Country. The Model of Care and the emergency management plan are artefacts inseparable from the practices within which they are enacted. Planning and articulating the Model of Care is a form of culturally-situated practice. Using plans in this way to orient action enabled Waminda to improvise, take risks and manage them responsively:

> *It was really high risk… we had to make calculated decisions all of the time. And some of the decisions might've been too risky but I suppose we were within our capacity of knowing what we had to do… We knew that it was high risk, and we knew that we had to be quite calculated about it. We would look at where the fire fronts were and where they were going and sometimes, they had to avert and not go to places. John was quite incredible, and he would ring me and say, "June I think if we stop at Mogo on the way home that's not going to give us enough time to get through X" and I'm like, "Okay well you can't go there today. You've got to come back".*

Discussion: implications and contributions

In summary, we used a practice-based approach to investigate the collective stories of people affected by consecutive environmental and public health disasters to identify the practices they experience as helpful in supporting healing, health and wellbeing for Aboriginal people, their communities and Country.

The bundles of practices articulated in this paper and enacted by Waminda during the bushfire crisis created a form of community deployment that was simultaneously sophisticated, strategic, organic, care-filled and healing. Waminda's practices were marked by a continuous 'yes' response, finding ways to meet the emerging care needs of Aboriginal communities for urgent and comprehensive support. These needs included access to timely communications and accurate information, water, food, clothing, prescription medications, temporary shelter, physical and mental first aid, and ways of connecting to family and community. The COVID-19 health crisis demanded other unexpected, emergent responses for and with service users, staff, and community members.

We do not claim that the articulation of practices enacted by Waminda are generalisable to all other organisations as both a limitation and strength of this study is that it is small-scale and contextually located. However, there are implications from this study that may be of interest to other ACCHOs, First Nations peoples, other regional and rural communities, and policymakers.

The paper contributes a suite of culturally safe and place-based practices that enhanced emotional, spiritual, social, and embodied well-being following cumulative disasters. These practice bundles include: adopting a Country-centred conception of local communities; being community-led; viewing care as a collective, relational sociomaterial accomplishment and having fluid boundaries. These practice bundles 'hang together' through organising practices including the Model of Care, the staff wellbeing framework and the emergency management plan which orientate action and manage risks. This

texture of interdependent practices are able to be adapted by health services in other rural and regional locations in response to pandemic conditions or other disasters. The paper suggests that crafting responses and implementing practices that focus specifically on assisting communities (re)gain their sense of belonging, hope for the future, control over their lives and their capacities to care for and to be cared for by Country, are key to enhancing healing, recovery, and well-being.

The paper makes a second contribution by demonstrating the need for disaster responses to be community-led and culturally situated. ACCHOs are shown to play a crucial role, and their local responses to immediate community needs are grounded in contextual knowledge and use existing resources rather than relying on mainstream system-wide interventions. ACCHOs, and other community-based organisations contribute to the fabric of a robust civil society which is essential for recovery and mitigates the mental health struggles common following disasters. The study demonstrates that Waminda's multigenerational, dense, horizontal networks enable such distributed, local responses and do not rely on top-down, centralised directives. Such practices are built on the strengths of local communities, culture, and Country in alliance with community organisations and members to enable recovery, healing, health and well-being. This paper joins calls [3, 26, 49] to recognise and fund the significant work of ACCHOs and other community-based organisations in disaster response and recovery.

The paper makes a third contribution by articulating the value of adopting a Country-centred conception of local communities. It points to the need to disengage from ongoing colonising frames of knowledge and practices that view settler relationships with Australian landscapes through ideas of 'wilderness'. These reinscribe First Nations' geographies as empty and available to settler priorities for conservation or colonisation [50, 51]. Such material-discursive practices are underpinned by assumptions of the separation of humans from nature and prioritise people and their built environment over Country for protection.

The significant finding of the discriminatory and racist responses towards Aboriginal people at evacuation and recovery centres evident in this study echoes research by Williamson [3]. The experiences of Aboriginal communities attest to the urgent need that Cadag [52] advocates to decolonise disaster risk, reduction, response and recovery practices, policymaking, and research. The colonised context, which this study shows, results in a deficit discourse of First Peoples, is sedimented, according to Sherwood [53], in the training of health professionals and imported into policies to describe First Nations people's health. The findings of this study demonstrate that the failure of mainstream healthcare systems and disaster response and recovery agencies to enact culturally-safe care with First Nations Australians is where the deficit manifests.

Learning from Country, valuing, protecting, and caring for Country, and connecting to Country through, for example, growing and catching food are critical practices that contribute to healing, health, social and emotional well-being following cumulative disasters.

The paper makes a fourth contribution by empirically demonstrating care as a knowledgeable doing, as collective, emergent, sociomaterial practices accomplished in ongoing, adaptive, open-ended responses to care needs [32, 54]. This relational view of care as practised is enacted within Waminda's model of care and healing framework. It offers an alternative to the view of care currently prevalent in the health and human services sector, which casts care as a transaction to be costed and delivered to an individual. Waminda's care practices and approach to healing provide a practical example of Quinn and colleagues [55] theoretical paper that advocates dialogue between First Nations peoples' healing and disaster recovery fields.

Finally, this paper makes a methodological contribution as to the authors' knowledge this is the first study to present a First Nation's ontological approach to practice theory in the context of disasters. The paper illustrates how Indigenous-informed, narrative inquiry, underpinned by practice theory, enabled a focus on doings, sayings and relatings, spiritual and sociomaterial arrangements at the local level. We were then able to trace these practices out to Waminda's key organising practices that coordinate and ensure the practice bundles, work together. Our analysis could then zoom out [43] to show that responses and response-ability are always situated and enacted in social, political, economic, and historical contexts. They are produced through dynamic and contested political processes and relations at the local level. For example, the care-filled relations, sense of belonging and connections generated through the Waminda responses are inseparable from the exclusionary, racist practices of some of the evacuation and recovery centres. Our paper suggests that yarning and storytelling will be among our most valuable practices for coming to imagine and to know what works and what is to be done [56]. This is significant as we face the immense challenges of climate-related crises in all their political, economic, ecological, and cultural diversity.

Given the projected increases in extreme weather events due to climate change, there is a pressing need for health services to become better equipped to address healing, recovery, and well-being in settings of cumulative disasters, especially with diverse and vulnerable populations living in rural and regional communities.

Conclusion

The organising practices of Waminda are an affective, political, and ethical call to learn to respond – to act care-fully, when outcomes cannot be guaranteed. A risky, committed, becoming involved in one another's lives, in diverse, passionate, practical, touching, meaningful ways. The capacity to quickly bring together and distribute resources, is built on many years of experience and commitment to servicing and standing with their communities. Perhaps, Waminda's response-ability offered a glimpse of safety and hope in the face of devastation–ways of responsibly imagining and affecting multiple traumas and injustices locally [57]. Waminda and their communities work together, 'push back' and struggle over justice that is yet-to-come so that Aboriginal women, their families, and their Country may live healthy, flourishing lives.

Abbreviations

ACCHOs	Aboriginal Community Controlled Health Organisations
COVID-19	Corona Virus Disease, 2019
SEWB	Social and Emotional Well-Being
ISLHD	Illawarra Shoalhaven Local Health District

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

Supplementary Material 3.

Supplementary Material 4.

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Authors' contributions

L.K, M.M. and S.L. wrote the main manuscript text, L.K. S.C. M.M. and S.F. collected the data, L.K., M.M. and S.C. analysed the data. L.K., M.M., S.C., S.L., K.F., S.F., C.D., R.E., J.A., M.F., P.P and K.O. reviewed the manuscript.

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Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly due to potential that transcripts of yarns and interviews with participants may lead to their identification but are available from the corresponding author on reasonable request and with permission of Waminda.

Declarations

Ethics approval and consent to participate

This study was approved by the Aboriginal Health and Medical Research Council Human Research Ethics Committee (no. 1779/21) and the Ethics Committee of The University of Wollongong & ISLHD Health and Medical Human Research Ethics Committee (no. 2021/ETH00110). All methods were carried out in accordance with guidelines and regulations including the five key principles required by the Aboriginal Health and Medical Research Council. Informed written consent to participate in the study was obtained from all participants.

Consent for publication

Informed consent for inclusion of the image that is attributed to the artists and thereby identifies them has been obtained for publication in an online open access publication.

Competing interests

L.K., M.M., S.C., S.F., S.L., J.A., C.D., R.E., M.F., P.P., K.O. report no competing interests. KF has a competing interest as she is employed by Waminda but was not involved in participant recruitment, data collection or analysis.

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