The experiences of Aboriginal Health Workers and Non Aboriginal Health Professionals working collaboratively in the delivery of Health Care to Aboriginal Australians: a systematic review of qualitative evidence.

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Aboriginal Health Worker

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Aboriginal Australians

Australia

Models of care

Aboriginal health care delivery

// Abstract

Background

Effective partnership between Aboriginal Health Workers and non Aboriginal health care providers is critical in reducing the health inequity facing Aboriginal Australians. Many factors can obstruct successful workplace partnerships causing them to be damaging and unproductive. Understanding the elements of best practice in forming and maintaining successful working partnerships between Aboriginal Health Workers and non Aboriginal health professionals is essential.

Objectives

To systematically review the qualitative evidence on the lived experience of interprofessional collaboration between Aboriginal Health Workers and non Aboriginal health professionals delivering care to Aboriginal Australians, with the view of identifying the perceived skills, knowledge, attitudes, management practices and institutional policies that enable successful interprofessional partnership.

Methods

A three-step search strategy, following the Joanna Briggs Institute method was used to find published and unpublished qualitative studies meeting set inclusion criteria. Critical appraisal and data extraction were completed using the Joanna Briggs Institute Qualitative Assessment and Review Instruments.

Results

Following the search and appraisal process, thirteen qualitative papers met the inclusion criteria for this review. From these studies, 436 findings were extracted and aggregated to form 40 categories. Seven meta syntheses were derived from the categories with key themes relating to the benefits of effective partnership for the practitioner, the health service and the Aboriginal community, negative experiences as a result of a disabling work environment, and empowering factors at the organisational, workforce and interpersonal/practitioner level which enable successful partnership.

Conclusions

Workplace culture and environments impact on the experiences of Aboriginal Health Workers and non Aboriginal clinicians working in collaborative clinical arrangements. When Aboriginal Health Worker's and non Aboriginal clinicians are empowered to work in a successful clinical partnership, through an enabling workplace, there is a great benefit experienced by both the practitioners, the Aboriginal community and the health service. When the workplace is a disabling environment to successful interprofessional partnership, this undermines the capacity of the Aboriginal Health Worker and non Aboriginal clinician to perform their roles within a partnership, resulting in negative experiences for the clinician, Aboriginal Health Worker and Aboriginal client.

Implications

Aboriginal Health Workers need to be supported in their roles by both the non Aboriginal workforce and employing organisation to deliver care that addresses the cultural, social, and preventative health needs of clients alongside the biomedical needs.

When embarking on collaborative work arrangements, Aboriginal Health Workers and non Aboriginal health care providers need training in each other's roles, responsibilities of delegation of care, mentoring and supervision, and cultural competency development.

Aboriginal engagement in health service delivery, planning and decision making at both the local and organisational level is vital. Aboriginal Health Workers need access to debriefing and cultural supervision to help negotiate the professional, personal and cultural obligations attached to their role.

Aboriginal Health Workers need a work environment and space that provides a culturally safe place to work, that includes culturally competent managers, visual displays representing Aboriginal culture and an overarching organisational culture committed to interprofessional partnership and Aboriginal cultural competency for all staff.

Aboriginal Health Workers also need access to quality training that is aligned with clearly articulated career development pathways that are adequately resourced, and delivered by a locally accessible educator. From a workforce perspective, further implementation of the career structure and governance around Aboriginal Health Worker registration proceeds to assist with the professional recognition of the role.

Statement of Originality

I, Carmel Mercer certify that this work is original and does not contain any material that has been accepted for the award of any other degree or diploma in any other university or tertiary institution. To the best of my knowledge and belief, it contains no material previously published or written by any other person, except where due reference has been made in the text.

I give consent for this copy of my thesis, when deposited in the University Library, to be available for loan and photocopying.

Signed

Date

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Chapter 1: Introduction

Context of the review

The arrival of white settlers to Australia over 200 years ago, came with a series of government policies designed to restrict basic human freedoms within the Aboriginal populations. The 1911 Aboriginal act and the 1923 Aboriginies Act took away the Aboriginal communities ability to self determine, assimilate children by the forced removal from their family and culture, and lack of citizenship and voting rights until 1967[(1)]. The current era of 'intervention' is further fuelling tensions, between Aboriginal and non Aboriginal Australians today, and amplifies the loss of culture, community and family connections that resulted from the implementation of these laws. The effect of these current and past policies within Australia's history continues to impact on Aboriginal and Torres Strait Islander (ATSI) people today, including the way ATSI people interact with health services and health institutions.

Difficulties remain with interactions between Aboriginal and non Aboriginal Australians, and through a process of reconciliation Australians are striving to improve these relationships [(1)]. Reconciliation is about understanding and building relationships, and reconciling history with the present. Reconciliation is a confronting process, it involves non Aboriginal Australians acknowledging and owning painful events and policies within Australia's history that has contributed to the loss of Aboriginal culture and marginalisation of ATSI people[(2)]. As with all Australians, health professionals are obligated to participate in the reconciliation process, by implementing within their practice ways of working more effectively with ATSI people to foster improved engagement in health care.

For health professionals this involves personal reflection on the contributions that their respective disciplines and health institutions have made towards ATSI people difficulty in accessing effective health care[(3)]. Alongside these difficult tensions, there is an attitude of suspicion amongst ATSI Australians towards non Aboriginal Australians, particularly towards people in positions of authority and health professionals[(4)]. The literature and current national policy acknowledges the importance of effective interdisciplinary collaboration between non Aboriginal health professionals and Aboriginal Health Workers, but also frequently makes reference to the difficulties in achieving this[(2)]. The health inequity experienced by ATSI people can be attributed to the impact of past Australian government policies, and the limitations this has placed on the Aboriginal social determinants of health[(5)].

Although there may have been some small improvements in recent years, the cultural distance between ATSI people and mainstream health services continues to influence the difficulties ATSI people experience when accessing health services. A predominant view is that there is a lack of knowledge among health service providers about what constitutes culturally safe care provision and health service models[4].

Australian health policy has called for an increase in the number of ATSI people participating in health service delivery to close the gap across the sector[6]. This has provided renewed opportunities for the Aboriginal Health Worker/Practitioner (AHW) workforce to engage with health care provision as many organisations have tried to increase their Aboriginal complement of workers[7]. Whilst engagement and partnering with Indigenous Australian's has been promoted the appropriateness of such approaches, has not been adequately explored[8].

AHW's are recognised as an important part of any health care delivery team trying to engage with and provide culturally responsive care to ATSI people. AHW's are trained primary health care professionals and soon to be registered under a national registration framework for health workers under the auspice of the Australian Health Practitioner Regulation Agency (AHPRA). The role encompasses that of translator, cultural consultant, policy development and planning, cultural advocate, mediator, clinical care delivery, and cultural mentor to clinicians. The AHW workforce makes a large contribution towards increasing the accessibility of health services to the Aboriginal community, by breaking down the barriers linked to cultural relevance and appropriateness of health service delivery[7]. Aboriginality as an essential component of the AHW role started appearing in the definitions of AHW from 1995[2, 9-11]. The basis of such a partnership is a mutual valuing of each others role and the willingness to learn from each other. All working relationships involve people bringing pre existing constructions to their interaction. Partnership can be seen as the interaction of the two sets of constructions and the result is the behaviours exhibited as a result of this interaction[12]. Professional groups also have their own dynamic sub cultures and unique ways of working[13]. Opposing values can either complement one another or amplify pre-existing assumptions. Forming successful interprofessional partnerships is a complex skill, and involves essential elements such as cooperation, collaboration, coordination and networking.

Despite the acknowledgement of the benefits of partnership between Aboriginal and mainstream organisations, barriers remain that prevent effective interprofessional partnerships between clinicians

and AHW's(8). Australia's colonial history, different professional values, dominant organisational culture, the reluctance to accept a different approach to care, and lack of resources and support have been quoted as possible barriers to facilitating effective partnerships[14].

If unilateral partnerships develop, this may impact negatively on the ability to meet the health needs of the Aboriginal community. There will also be poor retention of the AHW workforce, at a time when mainstream health services are recognising the value of integrating the AHW workforce into their service provision.

This review aims to explore the experiences of clinicians and AHW's working together, and identify the perceived skills, knowledge, attitudes, management practices and institutional policies that contribute to successful collaboration between AHWs and clinicians. By identifying the elements that are perceived by key stakeholders as contributing to a successful interprofessional partnership between clinicians and AHWs, strategies can be proposed to assist health organisations in supporting and improving such collaboration. This may aid the process of reconciliation between Aboriginal and non Aboriginal Australians.

An overview of the Aboriginal Health Worker Role, and workforce development within Australian health care settings

The role of the AHW as a successful contributor in improving Aboriginal health outcomes has long been recognised[15], and models of care involving collaboration between clinicians and AHW's have become recognised as the lead model of care reducing the health inequity facing Aboriginal Australians[15, 16]. The role of the AHW has been documented in Australia since the 1950's, and the workforce has grown rapidly since[15].Recently there has been a number of AHW workforce initiatives emerge to support and strengthen the AHW workforce, and to reflect the crucial roles they play in improving health outcomes for Aboriginal people. Development of the Indigenous Health Worker workforce is a part of The Aboriginal and Torres Strait Islander Workforce National Strategic Framework, endorsed in 2002 by the Australian Health Minister's Advisory Committee (AHMAC)[15]. Health Workforce Australia has recently completed their AHW Project[16] which has funded and progressed several initiatives outlined in the Aboriginal and Torres Strait Islander Workforce National Strategic Framework including improved clarity around the AHW role, and the professional regulation and recognition of AHWs. This has had an impact on AHW training across Australia. There has been a National alignment for AHW training through the Vocational Education and Training (VET) pathway, and the development of AHW role

competencies through the National Aboriginal and Torres Strait Islander Workforce Association NATSIHWA[17]. The Community Services and Health Industry Skills Council (CS&HISC) is the nationally recognised body funded by the Australian Government which governs the development of nationally applicable VET qualifications.

There are a number of pathways to enter the Health Worker profession, and recently some AHWs have been eligible to become registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia as Aboriginal and/or Torres Strait Islander Health Practitioners under the national law.

The Aboriginal and Torres Strait Islander Health Practice Board of Australia has currently set the minimum qualification for application for national registration with the Australian Health Professionals Regulation Authority (AHPRA) as the Certificate IV – Aboriginal and Torres Strait Islander Primary Health (Practice)[17].

AHWs work in a variety of work environments and within a variety of clinical and community specialties. Generally there are three branches of the role, one that is focused on work within health promotion, one that works within the community and one that is around acute clinical care delivery[17]. It is important to note that there are also a number of different titles used to describe Health Workers in the Australian literature. These titles do not necessarily correspond to a uniformed qualification supporting that role, or the speciality area that the worker works within. Some of the titles used may be mental health worker, education officer, hospital liaison officer, nutrition health worker, drug and alcohol worker, and environmental health worker[17].

A large majority of Australia's AHW workforce works within Aboriginal Community Controlled Health Organisations (ACCHOs)[7]. Many also work in the government health sector across mainstream health organisations traversing both acute hospitals and medical practices. AHWs perform their roles across metropolitan, regional and remote areas, with the largest number practicing in the regional areas of the Northern Territory[7].

At the present time there is no national picture of the numbers of workers in the Aboriginal Health Worker Workforce[7]. The collection of this data is compounded by several limitations. For example, presently there is no consistent definition of ATSI Health Workers used across Australia. Despite this there are several demographic factors that we know about this workforce. That is the distribution of the total Health Worker workforce does not align to the distribution of the ATSI population – 48% of the

Health Worker workforce is located in remote or very remote areas of Australia, whilst only 24% of the ATSI population is located in these areas[7]. Also, the majority of Health Workers are female (70%)[7].

The expert knowledge and skill around culturally safe care delivery performed by ATSI Health Workers is a defining characteristic of their role and function within a health care institution[18]. Whether the AHW works within the specialties of health promotion, community care or acute clinical care, this aspect of their role is fundamental to all AHWs. It is uniquely different to the role any other health professional can play in promoting the delivery of culturally safe health care services.

Statement of the review question

This review aimed to explore the following questions:

What are the experiences of Aboriginal Health Workers and Health Professionals working in collaborative clinical arrangements delivering care to the Aboriginal people?

What are the perceived factors within a health care organisation or service delivery models, which enable or obstruct successful working partnerships between Aboriginal Health Workers and health professionals?

Overview of the science of evidence synthesis

The historical and traditional positivist paradigm of scientific enquiry has provided much quantitative evidence emphasising the value and effectiveness of interventions aimed at improving health outcomes and providing an evidence base for influencing clinical practice decisions[19].

Within the last two decades, the positivist paradigm has been complimented by qualitative research methods, aimed at filling a void in lines of inquiry, where scientific and quantitative methods alone did not answer integral questions relating the understanding, meaningfulness or feasibility of certain health issues and interventions[20]. Qualitative research provides a much more appropriate methodology for answering these questions, and provides greater insights into health issues and interventions, from a 'holistic' perspective taking into account other factors such as context and cultural and social variables [19].

Qualitative research has proven its value alongside quantitative research, through its power to inform health care policy, and the planning and implementation of health care interventions. It does this

through its scope to illuminate how individuals and health care providers experience, understand and interact with health care, and how that influences decisions about health care [20].

A single, primary, qualitative research study has little power in informing or guiding practice. In the quantitative paradigm, synthesising randomised controlled trials has been seen as the 'gold' standard in evidence hierarchy. Synthesising qualitative evidence, through a process that is systematic, and with good rigour can also be viewed as having power within the evidence hierarchy[21].

There is much discourse amongst qualitative researchers regarding the merits of synthesising qualitative studies. Some researchers are concerned that by pooling qualitative findings, and applying similar methodologies to quantitative research, it destroys the vividness of the lived experience, at the heart of the experience it is trying to illuminate. Others argue that for the discipline of research to progress, the process of synthesising qualitative data is essential [19]. Evidence synthesis is the process of evaluating the research evidence on a specific topic to aid in decision making in health care, and is built around a model that considers theory, methodology and systematic review of evidence [21]. As a result strategies and processes for synthesising qualitative data in a way that still celebrates the uniqueness of the human experience have been developed.

Discussion of the methodological basis of the chosen approach to synthesis

This systematic review followed the Joanna Briggs Institute (JBI) review methods for qualitative synthesis, which articulates a structured approach to performing a systematic review, and deriving synthesised findings from the included qualitative studies.

The JBI methodology supports the use of synthesising qualitative findings, through a process of categorising and aggregating findings and conclusions. The JBI agreed method of synthesis[21] is outlined below and is discussed in further detail in Chapter 2.

1. Development of a rigorous study protocol
2. Clear articulation of study question
3. Identifying the inclusion and exclusion criteria for selection of studies to be included in the review
4. Formulation of search strategy that will identify relevant studies
5. Establishing a process for assessing the quality of each study to be included in the review through the critical appraisal process

6. Extracting data from the studies
7. Establishing a method of aggregating data collection to form a synthesis

The Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBIQARI) was used in this review to assist with the critical appraisal process, data extraction and synthesis of the findings of qualitative studies. JBIQARI is a module within the Joanna Briggs Institutes software for systematic reviews of literature, SUMARI (System for the Unified Management, Assessment and Review of Information).

The data synthesis contained in this systematic review was performed using the JBIQARI software program. The process of metasynthesis includes the aggregation or synthesis of the findings reported by the research participants in the selected studies contained in this review. Each finding was rated according to its credibility and placed within a category of similar meaning. The categories where then subjected to a metasynthesis in order to produce findings that can be used as a basis for evidence based practice. The JBIQARI module assisted in the process of categorising the findings, and synthesising the categories, and uses the JBIQARI formatting to present the results in Chapter 3.

Assumptions, limitations and delimitations

Even though a large volume of data was retrieved for this review, its limitations must be acknowledged. The difficulties encountered with identifying an appropriate set of search terms and the inconsistent way that studies pertaining to Australian Aboriginal health issues are indexed within the mainstream databases means that some relevant studies may have been missed.

Within the Aboriginal community, there is a huge amount of diversity existing across the Aboriginal population, each with their own unique set of cultural beliefs and practices. No doubt, the context of this diversity shapes and informs the experiences that are reported in this review from the perspective of the AHWs. For the purposes of this review, I have synthesised the collective findings of the Aboriginal participants who participated in the studies included in this systematic review, not wanting to misrepresent that they are diverse people, with no doubt, diverse factors shaping their reported experiences. Despite the diversity across the Aboriginal community there have been similar reported experiences from Aboriginal workers, clients and non Aboriginal health care professionals, and I have been able to group these into categories in order to formulate the final metasynthesis. The final metasynthesis informs the practice recommendations and is not intended to dilute or constrain the

cultural diversity. The practice recommendations, as a result of the methodologies employed in conducting this review, are developed from the collective view of those Aboriginal research participants' and their experiences. The proposed practice recommendations may not be absolutely transferrable to each individual health care setting, given the diverse context of the cultural diversity, however they will provide a framework for consulting with the Aboriginal community when developing and implementing models of care that involve partnering with AHWs.

Definitions of terms

Aboriginal Health Worker – An Aboriginal and Torres Strait Islander Health Worker:

> Identifies as an Aboriginal and/or Torres Strait Islander and is recognised by their community as such
>
> Holds the minimum (or higher) qualification in Aboriginal and Torres Strait Islander primary health care
>
> Has a culturally safe and holistic approach to health care.

Non Aboriginal Health Care provider – any registered health professional who does not identify as being an Aboriginal and /or Torres Strait Islander.

Interprofessional collaboration – where two or more health workers from different professional backgrounds provide comprehensive services by working with patients, their families, caregivers and communities to deliver the highest quality of care across settings.

Partnership – two or more people working together to achieve a common goal, each with unique knowledge and skillsets. The basis of partnership is a mutual valuing of each other's role and the willingness to learn from each other's unique knowledge and skillsets. Partnership can be seen as the interaction of the two sets of constructions and the result is the behaviours exhibited as a result of this interaction.

Cultural safe care – "the effective care of a person/family from another culture by a health care provider who has undertaken a process of reflection on their own cultural identity and recognises the impact of the health care professional's culture on their practice. Unsafe cultural practice is any action which

diminishes, demeans or disempowers the cultural identity and well-being of an individual" Nursing Council of New Zealand cited in[18]

Chapter 2: Methods

"We have a history of people putting Maori under a microscope in the same way a scientist looks at an insect. The ones doing the looking are giving themselves the power to define" (Merata Mita, cited in [22])

The following outlines the methodology used to undertake this systematic review of qualitative evidence for this thesis, using JBIQARI.

Review Questions

This review aimed to explore the following questions:

What are the experiences of Aboriginal Health Workers (AHWs) and Health Professionals working in collaborative clinical arrangements delivering care to the Aboriginal people?

What are the perceived factors within a health care organisation or service delivery models, which enable or obstruct successful working partnerships between AHWs and non Aboriginal health care professionals?

Inclusion Criteria

Criteria for Considering Studies for This Review

Types of Studies

This review included studies that focussed on qualitative data including, but not limited to, designs such as phenomenology, grounded theory, ethnography, action research and feminist research.

Types of Participants

This review considered studies that included non Aboriginal health service providers, AHWs, Aboriginal Liaison Officers and Community Health Workers working collaboratively to deliver care to Aboriginal Australians (considered as 'clients') in a variety of health care settings.

Phenomena of Interest

This review considered studies that investigated and reported on the experiences of AHWs and non Aboriginal health care providers in collaborative work arrangements and included the perspectives of

non Aboriginal health care providers and AHWs and clients (Aboriginal Australians) receiving care if available. This may include delivery of patient care related experiences, experiences involving organisation or context of working arrangements.

Context

The context within which this review is set, is within the Australian health care system. When reviewing the historical development of the Australian health care system, it was clear that the health practices of Aboriginal people were not incorporated into the development of the Australian health care system when it first emerged during the 19th century[(23)].

In the present day Australia's health care system has a legacy of being classified as an industrialised and welfare-orientated health care system[(23)]. This is characterised by the state provision of health care insurance for the majority of its population. This system relies on the Commonwealth Government sponsored public health insurance medicare[(23)]. This system of public health insurance is not means tested, and enables all Australian citizens access to free inpatient, outpatient and emergency treatment in a public hospital. Alongside this, individuals can elect to also access private health insurance schemes, for those electing to be treated in a private hospital.

Despite access to free health care services for all Australians, there exists today a considerable health inequity facing Aboriginal Australians when compared to non Aboriginal Australians[(7)]. Public hospitals are the largest component of the Australian health care system, and the majority of these are located in the metropolitan areas within Australia. The health inequity facing Aboriginal Australians is more severe when analysed from the perspective of regional and remote areas within Australia[(7)]. Health services need to be both available and culturally accessible to Aboriginal Australians. These are separate and distinct concepts. Barriers such as fear of racial discrimination, or receiving health care that does not ensure the cultural safety of the patient can render available health services inaccessible to Aboriginal and Torres Strait Islander (ATSI) people. AHWs are a key workforce strategy, working towards making the Australian health care system more accessible to Aboriginal Australians[(7)].

The health care workforce in Australia is large and diverse, with a total of 6.72% of Australia's employed citizens working in health care[(23)]. Nearly half of this workforce are registered health professionals, with the majority working within the nursing profession, followed by the medical profession, pharmacists, physiotherapists and other smaller health professional groups[(23)].

This review included analysis of studies set across metropolitan, regional/rural and remote health care settings across Australia. These health care settings were a combination of mainstream public hospitals, health clinics and health services operating from Aboriginal Community Controlled Health Organisations (ACCHO's).

Review Methods

Search Strategy

The search strategy aimed to find both published and unpublished studies. A three-step search strategy was utilised in this review. An initial limited search of MEDLINE and CINAHL was undertaken followed by analysis of the text words contained in the title and abstract, and of the index terms used to describe an article. This formed the basis of a preliminary logic grid as shown in Appendix I. A second search applying the preliminary logic grid to each database, using all identified keywords and index terms was then undertaken across all included databases. A research librarian was consulted in the initial stages of planning, due to the inconsistencies and limited searching effectiveness related to ATSI health literature. It is acknowledged that inconsistencies exist in the way that studies pertaining to Australian Aboriginal health issues are indexed within the mainstream databases[24].

Due to the difficult nature of the inconsistent indexing terms across the mainstream databases pertaining to Aboriginal health[24], the results of each search string when applied within each database has been included in Appendix I. Hand searching the Aboriginal and Islander Health Worker Journal was also a strategy employed in the searching process. Thirdly, the reference lists of all identified reports and articles were searched for additional studies. Only studies published in English were considered for inclusion in this review. Studies published between 1995 - 2012 were considered for inclusion in this review. Aboriginality did not form an essential component of the AHW role until 1995, when Aboriginality started appearing in the definition of an AHW[2].

The databases searched included:

CINHAL, Pub Med, Scopus, Embase.

The search for unpublished studies included:

Mednar, AHPRA publications, TROVE, Proquest Dissertations and Theses, Department of Health and Ageing, National Health and Medical Research Council. Australian Indigenous Health Infonet. Conference proceedings and Australian Digital Theses.

Initial keywords used to formulate the logic grid were:

interprofessional relations

Community Health Worker

Aboriginal Health Worker

Aboriginal Liaison Officer

health personnel

collaboration

community-institutional relations

Australia

Cultural safety

Cultural competence

Method of Review

As shown in Figure 1, a total of 9513 potential articles were identified after a thorough search through the databases using the predesigned search strategies specific to each database (Appendix I, Detailed Search Strategy). A further 23 studies were also identified after scanning the bibliography lists of the included studies and by hand searching the Aboriginal and Island Health Journal. Once 6438 duplicates where removed 3098 studies remained of which the titles and abstracts were assessed for relevance to fulfilling the objectives of this review. The full papers of the relevant studies (n = 56) where then retrieved for detailed assessment to ensure compatibility with the inclusion criteria of this systematic review. From these studies, 28 articles were excluded for not fulfilling the inclusion criteria and a further

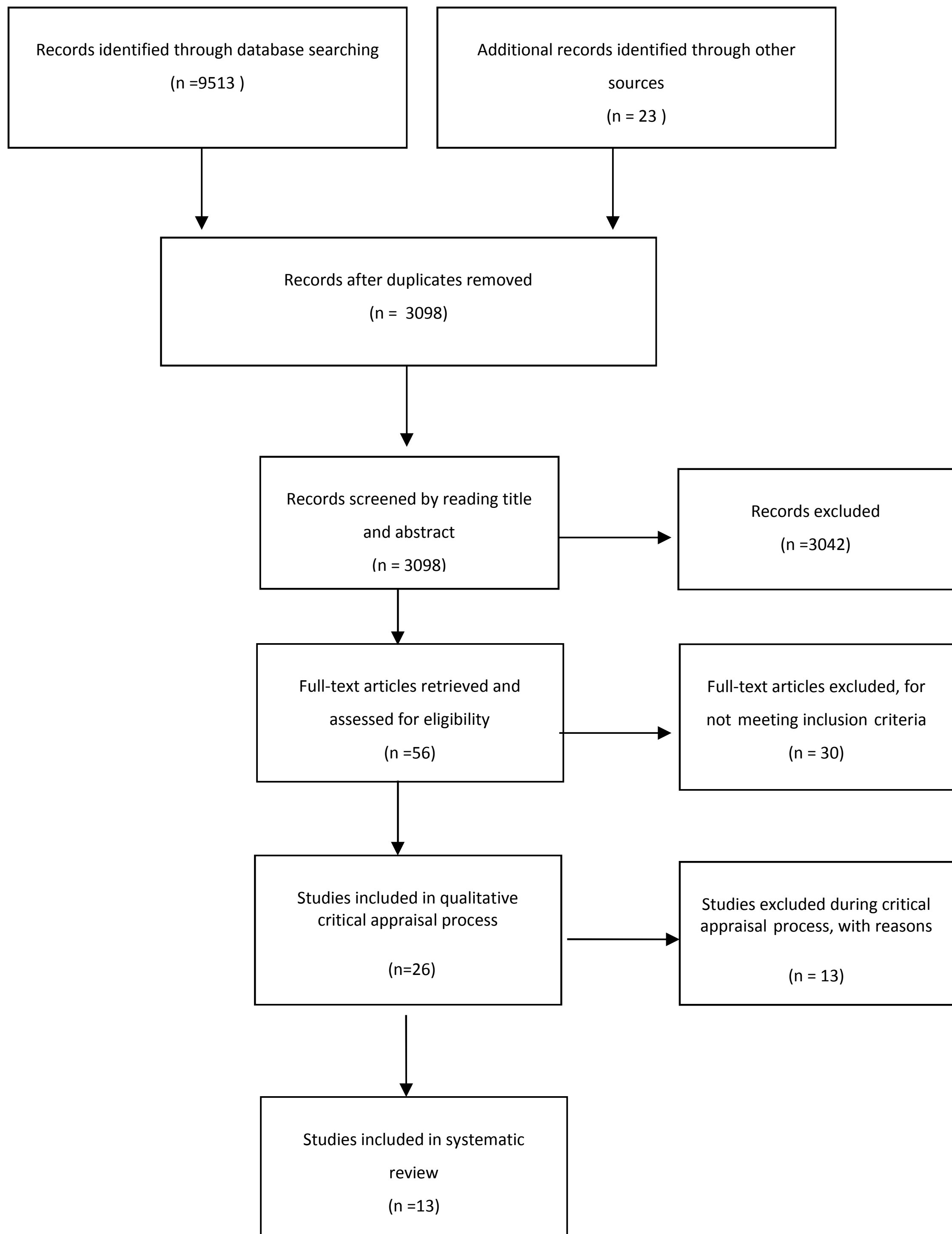
two studies were excluded as they were repeat reports of a study already included in this systematic review. Studies were eliminated from entering the critical appraisal process of the review for the following reasons:

- Focussed on partnership from an interagency/organisation perspective and not from an individual practitioner level

- Not focussed on the experience of interprofessional collaboration between AHWs and Non Aboriginal health care providers, and more on the clinical effectiveness of the model of care

- The AHW role in the model of care presented did not require the worker to work in a collaborative partnership with a Non Aboriginal health care provider

Figure 1. Flow diagram for retrieved studies, excluded and included studies



Assessment of Methodological Quality/Critical Appraisal

The shortlisted articles (n=26) were independently assessed for their methodological quality by two reviewers using JBIQARI. Results of critical appraisal in JBIQARI of included studies can be seen in Appendix II. A third reviewer to resolve any disagreements was not required. The reviewers agreed prior to critical appraisal that studies must meet at a minimum, seven of the ten criteria in the JBI-QARI Appraisal Checklist (see Appendix III). Of the ten criteria it was essential that the study met criteria seven 'the influence of the researcher on the research is addressed', criteria eight 'participants, and their voices, are adequately represented', and criteria nine 'the research is ethical according to current criteria or for recent studies there is evidence of ethical approval by an appropriate body'.

In an effort to privilege the voices of the Aboriginal research participants, appropriate methodology needed to be applied in order to be included in the systematic review. Meeting criteria seven, that the influence of the researcher on the research, and vice – versa is addressed was a priority. This is in recognition that formal research methodologies have evolved from an Anglo-Celtic epistemology[25] and when applied to Aboriginal communities has the risk of becoming misguided or harmful to the population it is exploring. There is the potential that a non Aboriginal researcher may indirectly impose their own values and judgment and interpret the Aboriginal experience from a non Aboriginal world view. Appropriate research methodologies employed for researching Aboriginal perspectives are aimed at decolonizing methodologies, in an effort to understand Aboriginal experience from their own perspectives[26]. This requires methodologies that enable Aboriginal self determination to the highest degree, building the capacity of Aboriginal researchers into the future[25]. At the very least researchers need to be consulting with the Aboriginal community at all stages of the research process ensuring the research is consistent with Aboriginal cultural values and concepts of health[25].

In relation to criteria eight, AHWs not belonging to mainstream culture can be seen as a marginalised group when considering all the participants in this review. It was imperative that to privilege the 'voices' of the AHWs, the qualitative data contained in the studies needed thick descriptions and strong representation. The reviewers deemed this essential in order to enhance the faithfulness to the Aboriginal world view, considering the hierarchical nature and structures within the health care environment.

In relation to criteria nine, all studies were ensured to have received appropriate ethics approval and permission to be conducting the research with the Aboriginal community. Ethical research guidelines have been developed by the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) – Guidelines for ethical research in indigenous studies[27] and the NHMRC – Guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research[28]. Ethical guidelines regulate relationships between the researcher and the Indigenous community, and ensure Indigenous involvement in research projects and promote respect for Indigenous knowledge and values. One author was contacted[2] to ensure that appropriate ethics approval from a Human Research Ethics Committee (HREC) had been obtained or joint approval from both an Aboriginal and an organisations research and ethics committee. This information was not reported in the published study. The author responded and confirmed that permission to conduct the study was received through a HREC.

All studies included in this review, see Appendix V: Included studies, were assessed on the above guidelines[27, 28] to ensure that those included did privilege the indigenous world view. It was important that the views and opinions of the Aboriginal participants weren't altered due to the power relationship of Western research paradigms.

With the exception of three studies[2, 29-32] the remaining studies in this review did not articulate the philosophical perspectives on which their studies were based. Regardless, based on the above reasoning, these studies were included in this systematic review because the research design, data collection methods, analyses and findings were faithful to the nature and requirements of qualitative and Aboriginal research methodologies.

The studies that were excluded during the critical appraisal process are outlined in Appendix VI.

Data Extraction

Qualitative data were extracted from studies included in the review using the standardised data extraction tool from JBIQARI (Appendix IV). The data extracted included specific details about the phenomena of interest, populations, study methods and outcomes of significance to the review question and specific objectives.

Data Synthesis

In this review, qualitative findings were pooled using JBIQARI. This involved aggregation or synthesis of findings to generate a set of statements that represented that aggregation, through assembling the findings (Level 1 findings) and rated according to their quality. Next, followed the categorisation of these findings on the basis of similarity in meaning (Level 2 findings). These categories were then subjected to a metasynthesis in order to produce a single comprehensive set of synthesised findings (Level 3 findings) that can be used as a basis for evidence-based practice.

Included findings were read and re-read for similar meanings and supporting quotes (illustrations) were extracted. Each level one finding was assigned a level of credibility according to the QARI module. The levels of credibility were as follows:

> Unequivocal (U) – relates to evidence beyond reasonable doubt which may include findings that are matter of fact, directly reported/observed and not open to challenge.
>
> Credible (C) – those that are interpreted, and deemed plausible in light of data and theoretical framework. They can be logically inferred from the data. Because the findings are interpretive they can be challenged.
>
> Not Supported (NS) – when neither 1 nor 2 apply and when most notably findings are not supported by the data.

The thirteen studies considered for this systematic review amassed a total of 436 findings (level one findings). If a level one finding was assigned as NS then it was excluded from the meta-aggregation.

Those findings with a level of credibility of U and C were integrated into 40 categories (level two findings), based on similar meanings. The themes or findings derived by the authors from the thirteen studies often contained multiple dimensions, which made it impossible to limit some individual findings to one category. After careful consideration by the reviewer, some findings were allocated to more than one category, at times belonging to different meta-syntheses, to allow a more comprehensive understanding of the phenomena of interest in this review. Repeated findings are indicated as (R).

These categories were then subjected to a metasynthesis in order to produce seven metasyntheses (level three findings) that can be used as a basis for evidence based practice. Within the following, evidence in the form of illustrations, observations and participant quotes, have not been adjusted for

correctness in English expression and punctuation. This data is authentic to the way it was presented in the original published articles.

Chapter 3: Results

This chapter reports on the results of the systematic review, details the descriptions of the included and excluded studies, and the conclusions extracted with the levels of credibility assigned. The results of the synthesis are reported by presenting each synthesised finding. With each synthesised finding there is a visual JBIQARI view, which demonstrates the relationships between the findings (level one finding), categories (level two finding) and synthesised finding (level three finding).

Description of Studies

Thirteen studies[2, 8, 16, 29-38] addressed the predetermined methodological quality during the appraisal process and were included in this systematic review (Appendix V). The thirteen included studies reflected the diversity of health settings that AHWs work within including that of mainstream health care settings, Aboriginal community controlled across metropolitan, regional and remote areas of Australia. All thirteen studies addressed the lived experience of AHWs and clinicians working in collaborative working practices delivering clinical care to Aboriginal Australians. Four[8, 30, 34, 37] of the studies, included in their analysis the experience of partnership from the perspective of the Aboriginal client receiving care. Eight studies[2, 8, 16, 30, 32, 35, 38, 39] analysed the experience of partnership from both the AHW and non Aboriginal health professionals perspective, and one study[31] focused entirely of the views of the AHWs. One study[32] was a thesis used for the completion of the award of doctor of philosophy, and one study[29] was a thesis produced for the award of a masters level qualification. One study[31] was a publication resulting from a masters level award.

Two of the included studies[34, 36] used mixed methods methodologies, and the remaining studies used qualitative methodologies exclusively.

Five of the studies[2, 29-32] included in this review had a clearly stated philosophical perspective. Of these, two[2, 31] were grounded in feminist perspective, one study[32] was grounded in a social constructionism paradigm, and one study[30] from a phenomenological perspective.

All studies where ensured to be addressing Aboriginal research methodologies appropriately during the critical appraisal process. Eight studies[8, 16, 29, 30, 32, 34, 37, 38] included ethics approval from both a HREC and an Aboriginal specific ethics committee or permission from an Aboriginal community group to complete the study. Three studies[29, 31, 37] included participants involvement in the development of the

research process, the research findings and conclusions by using a participatory action framework in the study methodology. All thirteen included studies used an Aboriginal advisory group, or an Aboriginal community, or Aboriginal person to oversee the methodological processes. Six studies[2, 8, 30, 34, 37, 38] used an Aboriginal co researcher as part of their research team, that was acknowledged as a co author to the study.

All studies included in this review ensured that the participants voices included in the review did privilege the indigenous world view. These studies ensured that the views and opinions of the Aboriginal participants weren't altered due to the power relationship of Western research paradigms.

In terms of methodological quality were the 13 studies considered to be of high quality

Review Findings/Results

Metasynthesis of studies included in the review generated seven Synthesised Findings. These Synthesised Findings were derived from 436 Study Findings that were subsequently aggregated into a 40 Categories (see Appendix VII, List of Study Findings/conclusions, to review all study findings and illustrations).

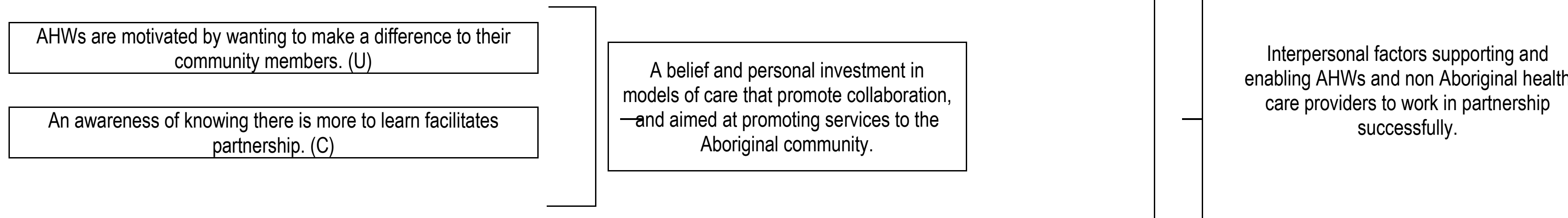
Synthesised Finding One

The first synthesis relates to interpersonal factors supporting AHWs and non Aboriginal health care providers to work in partnership successfully, and was made up of a total of three categories generated by 35 findings.

Synthesis One: Interpersonal factors supporting and enabling AHWs and non Aboriginal health care providers to work in partnership successfully.

AHWs and non Aboriginal health care providers are required to build and maintain positive, multidisciplinary relationships with each other. In order to do this effectively, interpersonal skills and qualities need enacting, such as a personal commitment to and a belief in models of care that support collaboration designed to reach the Aboriginal community. Knowledge of 'White' privilege, and the difficulties that Aboriginal employees face when working within a mainstream health system were also seen as advantageous. Knowledge of how to mentor each other around the respective cultural and clinical aspects to care was also a feature. Essential qualities reported were also, honesty, humility and reflective capacity.

Finding	Category	Synthesised Finding



Commitment as a quality to work with Aboriginal community. (U)

Health professionals also learn, when working with AHWs. (U)

It takes more time for a health professional to work inter-culturally. (U)

Professional collaboration improves services for the client. (U)

AHWs felt it important that White workers had awareness and understanding of Aboriginal history and culture, and their own 'whiteness'. (U)

AHWs find barriers to their role in the structures and management of their workplace. (C)(R)

An awareness that racism exists is an enabler to good relationships. (C)

Colonial history impacts negatively on the relationships between Aboriginal and non Aboriginal staff. (U)

Health professionals also learn, when working with AHWs. (U)

Health professionals need to understand colonisation and continuing impacts. (U)

Hospitals represent colonialism for the Aboriginal community. (U)

Lack of educational opportunities disempower AHWs (C)

Negative personal experiences impact the White health professionals ability to work with Aboriginal staff. (U)

Acknowledgement and addressing of White privilege, and the professional culture within each discipline, within the work collaborations.

Interpersonal factors supporting and enabling AHWs and non Aboriginal health care providers to work in partnership successfully.

Non Indigenous staff attitudes act as a barrier to the Aboriginal community. (C)

Not providing staff with cultural awareness training was seen as a barrier to building good relationships with the Aboriginal community and workers. (U)(R)

Nurses tend to position themselves as 'in charge' (C)

Personal experience enabled health professional to work with Aboriginal people. (U)

Reconstructuring the professional culture of the professional group the health professional belongs to. (U)

Some non Aboriginal health staff struggle with AHWs attending clinical meetings. (U)(R)

Strategies for white workers include acknowledging your White privilege. (U)

The 'white' dominance in the workplace, impacts negatively on AHWs. (U)

White people need to let go of white judgement for health relationships. (U)

White workers need to have an awareness of their position of power. (U)

White workers relinquishing control is an important strategy for working with Aboriginal people. (U)

AHWs are happy in the work environment if they have a non Aboriginal health care provider who wants the model of care to be a success and shares clinical knowledge. (U)

AHWs value working alongside non Aboriginal health care providers who value what they say. (U)

Discussion occurs between Aboriginal and non Aboriginal staff. (U)

Honesty and persistence described by both AHWs and White professionals. (U)

Humility raised as an important quality for White professionals. (U)

Non judgement communicates respect and fosters trust. (U)

Reciprocity important to relationship building (U)

Respectful communication is important for working with AHWs. (U)

Strategies for White workers include acknowledging your knowledge gaps and expectations. (U)

White workers need to learn about Aboriginal culture using their own initiative. (U)

Honesty, humility and a personal commitment to ongoing learning.

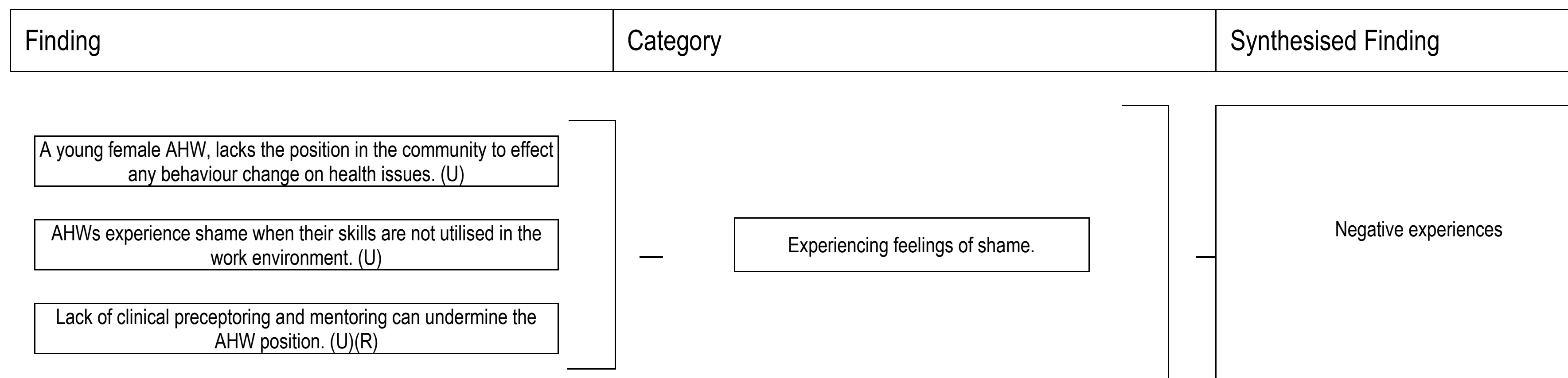
Interpersonal factors supporting and enabling AHWs and non Aboriginal health care providers to work in partnership successfully.

Synthesised Finding Two

The second synthesis relates to the negative experiences of AHWs and non Aboriginal health care providers when working collaboratively to deliver clinical care. It is an aggregation of eight categories informed by 85 findings.

Synthesis Two: Negative experiences experienced by both the AHW and non Aboriginal health care provider.

AHWs and non Aboriginal health care providers when working in collaborative work arrangements are confronted with many negative experiences resulting from organisational, workforce and interpersonal barriers impacting on effective partnership. There appears to be an overwhelming feeling of a lack of preparedness to work in collaboration reported across all professional groups, and significant reports of feeling culturally unsafe and not valued in the workplace by the AHWs. The AHWs also reported difficulties with managing both the communities and health services' expectations of them, resulting in emotional burnout. A lack of understanding of each other's professional roles, and misinformed expectations of each other's professional role within the partnership may compromise the value and benefits of the collaboration.



AHWs experience difficulties when not provided with adequate training for their role. (U)

AHWs feel stressed providing social and emotional support due to the lack of role support. (C)

AHWs need further training in counselling (C)

AHWs need training which helps them bridge the Indigenous/non-Indigenous approaches to health care delivery. (C)

Cert IV qualifications are necessary to enable AHWs to work in autonomous roles. (U)

Clinicians lack the skills and experience to support AHWs in implementing community development work. (U)

Clinicians struggle providing care that is not delivered in the clinical paradigm in which they have been trained. (U)

Community members believe that more qualifications for the AHW will lead to increased workplace equity for the AHWs (U)

Community members do not have confidence in the training that AHWs receive, and therefore bypass the AHW. (U)

Fragmented training blocks impact on consolidation and implementation of knowledge for the AHW (U)

Health professionals desire AHWs to have specialised training. (U)

Health professionals request more support around language and culture. (U)

Nurses have an educative role for non nurses (C)

Feeling unprepared to practice role in a collaborative work arrangement.

Negative experiences.

There is no support or emphasis on the teaching role that non Aboriginal staff have when working with an AHW. (U)

AHWs experience work place inequity (C)

AHWs are disempowered in their work environments. (U)

AHWs are not renumerated for the actual hours worked. (U)

AHWs are prevented from translating their clinical knowledge into clinical practice. (U)

AHWs cultural knowledge needs valuing. (U)

AHWs don't feel valued in the health system. (U)

AHWs experience mistrust in their roles. (U)

AHWs experience paternalistic attitudes from supervising professionals. (U)

AHWs feel excluded from clinical goal and strategy planning meetings because of the different medical language that is used at these meetings. (U)

AHWs feel not trusted to perform their role by other health professionals. (C)

AHWs feel they have no voice in the health system (U)(R)

AHWs feel undervalued in the workplace. (C)

AHWs find barriers to their role in the structures and management of

Feelings of being undervalued, unacknowledged and that skills are underutilised.

Negative experiences

their workplace. (C)(R)

AHWs find not being paid outside of their contracted hours as a barrier to their roles. (U)

AHWs have a cultural scope of practice complementing a clinical scope. (U)

AHWs have limited opportunities created for them to implement certain skills that they have had the training for. (U)

AHWs lack clinical opportunities to translate their clinical training into practice. (U)

AHWs often are forced to take on an ancillary role in the health care setting. (U)(R)

Differences in working conditions are experienced by AHWs (C)

Evaluation methods of AHW models of care need to take into consideration the nature of the AHW role. (C)

Hospital environment favours Aboriginal staff being in an ancillary role compared to a clinical role. (U)

In the interests of efficiency AHWs are excluded because to involve AHWs in care takes much longer. (U)

Lack of confidence in the English language by AHWs limits the AHWs sense of authority comparable to non Aboriginal health staff. (U)

Lack of Professional recognition for AHWs. (C)

Reciprocity seen as important to AHWs. (U)

Some non Aboriginal staff can see the system and the organisation of work inherently devalues the AHW which impacts on work attendance. (U)

The complex social issues in the Aboriginal community impacts the AHW practicing to their full scope of practice. (U)

The cultural knowledge of AHWs needs valuing. (U)

There needs to be nationally consistent pay scales for AHWs. (C)

There is a lack of equity regarding the benefits non Aboriginal staff receive, compared to the benefits AHWs receive whilst working for the health service. (C)

Irregular work attendance by AHWs impact on their sense of ownership in the work space. (U)

Non Aboriginal staff believe they cannot instigate any preventative health programs as AHWs are often absent from work. (U)

Non Aboriginal staff struggle with the haphazard and inconsistent working hours of AHWs. (U)

Frustration with lack of attendance at work.

Health professionals working alongside AHWs need to be on permanent contracts. (C)(R)

High staff turnover is challenging. (U)(R)

Staff turnover is a barrier to providing care to the Aboriginal community. (U)(R)

Frustration with lack of continuity in work relationships.

Negative experiences

Turnover problems with AHWs (U)

AHWs experience high scrutiny regarding the visibility of their roles. (C)

AHWs fear 'pay back' from their communities when performing their job roles. (U)

AHWs feel an acute sense of community obligation and responsibility. (U)

AHWs find it too hard to leave their families/communities to participate in training. (U)

AHWs find not being paid outside of their contracted hours as a barrier to their roles. (U)

AHWs get tired of being available to the community all the time. (C)

AHWs work a lot outside of working hours due to the cultural/community obligations. (U)

Connectedness to the community can be a barrier to the AHW role. (U)

Cultural needs of the community takes primacy for AHW. (C)

Fear of payback from the community may limit a AHWs ability to be involved in treatment of a community member. (U)

Health professionals view AHWs that are able to understand both Aboriginal and non Aboriginal culture as being an advantage to their role. (U)

Navigation of two worlds: Difficulty balancing the community's/cultural expectations, with expectations of health service, and training requirements.

Negative experiences

Lack of family support can be a barrier to training. (U)

Navigating the 'two worlds'. (U)

Nurses do not understand AHWs are accountable to the community first. (C)

AHWs encounter the complex social/emotional needs of the community. (U)

AHWs are not renumerated for the actual hours worked. (U)

AHWs are still working when they have left work due to their connectedness with the community. (U)

AHWs experience burn out due to the close connections they have with their community. (U)

AHWs experience frustration by not being able to take on a preventative approach to health care. (C)

AHWs experience the health inequity between Aboriginal and non Aboriginal Australians. (U)

AHWs get tired of being available to the community all the time. (C)

AHWs need formal debriefing to manage compassion fatigue. (U)(R)

AHWs work a lot outside of working hours due to the cultural/community obligations. (U)

Occupational work hazards: emotional burnout

Negative experiences

Non Aboriginal health care providers are aware of not putting unreasonable workloads on AHWs (U)

Synthesised Finding Three

The third synthesis relates to the organisational factors impacting on AHWs and non Aboriginal health care providers when working collaboratively to deliver clinical care. It is an aggregation of five categories informed by 62 findings.

Synthesis Three: Organisational factors that support and enable AHWs to work in partnership with non Aboriginal health care providers effectively. The culture of the health organisation in terms of its ability to meet the cultural needs of Aboriginal people and Aboriginal employees, its ability to listen to and accommodate the voices of Aboriginal participants when making decisions about implementing and delivering health services and fostering a culture of building interprofessional collaboration are seen as an essential foundation when building a work environment capable of fostering successful workforce collaborations between Aboriginal and non Aboriginal health care providers.

Finding	Category	Synthesised Finding

Greater AHW participation in decision making will improve accountability. (U)(R)

Health professionals request cultural learning from elders in the community. (U)

Health services should encourage community participation. (U)

AHWs and the community must be encouraged to take a more participative role with the health service. (C)(R)

AHWs must be enabled to participate in decision making about how the health services are delivered at a much greater level. (C)(R)

Increasing the AHWs clinical focus in their work would empower AHWs and assist the health service. (U)

Over dominance of white health professionals in the work environment impacts on AHWs feeling of pride in their abilities. (C)

The community recognises that the AHWs does not have a voice in the health clinic, and the health clinic is not accountable to the community it serves. (U)(R)

White workers need a broader view of their professional role, to enable practice with Aboriginal communities. (C)(R)

White workers relinquishing control is an important strategy for working with Aboriginal people. (U)

AHWs need to apply for funding to sustain their programs. (C)

Access to adequate resources to deliver quality health services in accordance with the Aboriginal communities' needs and

Organisational factors that support and enable AHWs to work in partnership with non Aboriginal health care providers

Inappropriate lack of Aboriginal employees. (U)

The shortage in AHWs prevents AHWs performing their health promotional/ prevention roles. (U)

expectations.

effectively.

AHWs and non Aboriginal health professionals need to work together on preventative health issues. (U)

AHWs bring a spiritual view of health. (U)

AHWs experience frustration by not being able to take on a preventative approach to health care. (C)

AHWs have a health prevention focus in their care delivery. (U)(R)

AHWs see value in working from a primary health care perspective. (U)(R)

Aligning health agenda's with communities needs. (U)

Non Aboriginal health care providers feel unable to support AHWs in health promotion and counselling. (U)

Community based approaches are successful in meeting local health needs. (U)

Ensure AHWs develop and maintain links with primary health care services. (C)

Health services do not enable AHWs to have a role in the provision of comprehensive primary health care. (C)

Mainstream health organisations do not meet the needs of the

Health care delivery is orientated towards and accommodates an Aboriginal definition of health: focuses on prevention rather than curative, and addresses connection to culture and country as important determinants in health status.

Organisational factors that support and enable AHWs to work in partnership with non Aboriginal health care providers effectively.

community. (U)

Mainstream health organisations need to become culturally aware of the needs of the Aboriginal community. (U)(R)

Preventing and managing chronic disease is unavoidable when addressing the health needs of the Aboriginal community. (C)

Structured natures of mainstream services are seen as a barrier. (U)(R)

AHWs need access to cultural supervision. (U)

AHWs prefer to be managed by Aboriginal staff. (C)

AHWs view Indigenous symbols displayed in the workplace as a sign that the hospital was supporting them in their role. (U)

Display of the Aboriginal flag in the workplace communicates commitment to the reconciliation process. (U)

Ensuring AHWs are supported will enhance the organisations ability to work with the Aboriginal community. (U)

Having a service based in the community was desirable for the community. (U)

AHWs must be enabled to participate in decision making about how the health services are delivered at a much greater level. (C)(R)

Inflexible organisation structure poses problems for White professionals working with Aboriginal workers and people. (U)

Organisational culture and support: culturally sensitive and responsive to the needs of Aboriginal people and Aboriginal employees, and values interprofessional collaboration.

Organisational factors that support and enable AHWs to work in partnership with non Aboriginal health care providers effectively.

Lack of partnership. (C)

Mainstream health organisations need to become culturally aware of the needs of the Aboriginal community. (U)(R)

Non Aboriginal staff see all staff members as equals. (U)

Non Indigenous staff attitudes act as a barrier to the Aboriginal community. (C)

Operating in 'silo's' can inhibit relationships between Aboriginal and non Aboriginal staff. (U)

Organisation culture promotes partnership. (U)

Organisational culture is important for enabling White workers to work with Aboriginal people. (U)

Policies in mainstream organisations do not adequately address the needs of Aboriginal people in the organisation. (U)

Some non Aboriginal health staff struggle with AHWs attending clinical meetings. (U)(R)

Structured nature of mainstream services are a barrier. (U)(R))

Supportive management practices contribute to AHW satisfaction at work. (C)

AHWs feel they have no voice in the health system. (U) (R)

AHWs find barriers to their role in the structures and management of their workplace. (C)(R)

Privileging of Aboriginal voices in high level decision making.

Organisational factors that support and enable AHWs to work in partnership with non Aboriginal health care provider effectively.

AHW;s need to be included in strong management processes and structures. (C)

Cultural knowledge leads to recognition for AHWs. (C)

Greater community participation in NHC[name of health service] will improve accountability (U)(R)

Greater AHW participation in decision making will improve accountability. (U)(R)

AHWs and the community must be encouraged to take a more participative role with the health service. (C)(R)

AHWs must be enabled to participate in decision making about how the health services are delivered at a much greater level. (C)(R)

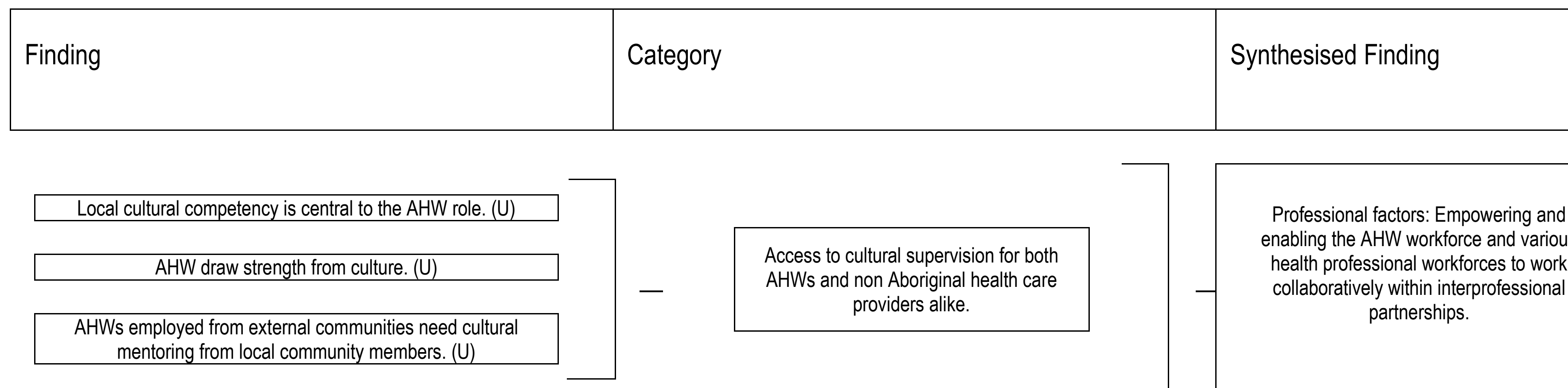
The community recognises that the AHWs does not have a voice in the health clinic, and the health clinic is not accountable to the community it serves. (U)(R)

White workers need a broader view of their professional role, to enable practice with Aboriginal communities. (C)(R)

Synthesised Finding Four

The fourth synthesis relates to professional and workforce factors empowering and enabling AHWs and non Aboriginal health care providers to work collaboratively when delivering clinical care. It is an aggregation of 11 categories informed by 102 findings.

Synthesis 4: Professional factors: Empowering and enabling the AHW workforce and various health professional workforces to work collaboratively within interprofessional partnerships. The AHW workforce is expected to build and maintain positive, multidisciplinary relationships with a variety of health professional workforces in order to improve health outcomes for Aboriginal Australians. This is underpinned by each workforce acknowledging each other's role in the professional partnership and being clear of each other responsibilities in the collaborative arrangement, and that this role is acknowledged from the relevant professional organisations and bodies. Professional recognition of the unique contribution the AHW workforce plays to each professional body is paramount, and is further reinforced by the professional accreditation of the AHW training courses. The AHW workforce is a small workforce, recently developing professional status within the health care arena, has much to gain by networking with other AHWs across Australia and growing their professional body. Programs that address the gaps in literacy, recruitment and retention issues, and culturally sensitive management practices would empower the AHW workforce to take an equal place in Australian health care settings.



AHWs need access to cultural supervision. (U)

AHWs need formal debriefing to manage compassion fatigue. (U)(R)

AHWs need to be from the same cultural community as their clients. (U)(R)

Health professionals request more support around language and culture. (U)

Health professionals request cultural learning from elders in the community. (U)

Important to maintain traditional practices. (U)

Responsibility of elders to teach younger women. (U)

Successful appointment of AHWs takes into consideration the complex kinship and cultural ties. (U)

The community want AHWs that come from the specific Aboriginal community they are providing health services too. (U)

AHWs want access to professional development and training opportunities. (U)

Colonial history impacts negatively on the relationships between Aboriginal and non Aboriginal staff. (U)

Forums for the Aboriginal community and non Aboriginal staff to share knowledge. (C)

Access to ongoing professional development opportunities which includes joint training opportunities and opportunities for reflective practice.

Professional factors: Empowering and enabling the AHW workforce and various health professional workforces to work collaboratively within interprofessional partnerships.

Reflection and reflexivity engaged in by health professional. (U)

Lack of resources prevent training in local communities of AHWs. (U)

Limited access to an AHW educator creates frustration for the AHW trainee and delays completion of qualification. (U)

Non Aboriginal health staff view AHW training as lacking rigour and impacting negatively on their working relationship with AHWs. (U)

Non Aboriginal health workers believe that poor quality training disempowers the AHW in the health system. (U)

Poor liaison between the AHW educator and the non Aboriginal health care providers means that there is no connection between what the AHWs learn in the formal teaching blocks and their work in the clinics. (U)

Positive training experiences and support helps retain AHWs in their roles. (U)

Qualifications assist with AHWs being observed as equal 'expert' members of the health care team. (U)

Record of AHWs level of competency and health knowledge is not communicated to the non Aboriginal staff. (U)

The challenge of backfilling AHW positions prevents access to training. (U)

The clinical demands prevent the passing on of clinical knowledge and mentoring to AHWs. (U)

AHW training is properly resourced and accredited, with an educator that is locally accessible to the trainees, and delivery takes into account the needs of Indigenous learners.

Professional factors: Empowering and enabling the AHW workforce and various health professional workforces to work collaboratively within interprofessional partnerships.

Training methodologies for AHWs need to be inclusive of Aboriginal traditional learning styles. (U)

Unavailability of training programs are a barrier for AHWs.(U)

AHWs did not understand the role of the nurse. (C)

AHWs experience other health professionals not understanding the scope of their roles. (U)

AHWs find that the non Aboriginal health staff do not provide them with enough training with the clinics. (U)(R)

Ambiguity around the AMIC[Aboriginal and maternal infant care] role causes anxiety for the health professional. (U)

Clearer AHW roles will improve accountability. (U)

Conflict exists around the role of the AHW being either clinically focussed or being health promotional focussed. (U)

Confusion over the AHW role being social or clinical. (U)

Have a clear definition of the AHWs role. (C)

Health professionals working in organisations employing AHWs need education on the role of AHWs. (U)(R)

Lack of clinical preceptoring and mentoring can undermine the AHW position. (U)(R)

Nurses lack knowledge and understanding about the roles and function of AHWs. (C)

Clearly articulated roles for both AHWs and non Aboriginal health care providers when embarking on a working partnership, which also addresses the mentoring aspects of collaborative roles.

Professional factors: Empowering and enabling the AHW workforce and various health professional workforces to work collaboratively within interprofessional partnerships.

The ambiguity of the AHW role causes difficulties for non Aboriginal health care providers. (U)

An unclear job description for the AHW role causes confusion. (U)

Increase understanding of the different professional role of each partner. (U)

AHWs become dissatisfied in their roles due to lack of career structure. (C)

Lack of career progression opportunities. (C)

Lack of career structure impacts on AHWs retention rates. (U)

Lack of recognition of prior learning and skills is a barrier preventing AHWs moving into other workforces. (U)

Perceived lack of career progression prevents people accessing training opportunities. (U)

The AHW role provides opportunities for articulation into other workforces. (U)

Developed career pathways for the AHW which outlines articulation into other health care roles.

Professional factors: Empowering and enabling the AHW workforce and various health professional workforces to work collaboratively within interprofessional partnerships.

AHW benefit from knowing how to work within or interact with mainstream health services. (U)

AHWs employed from external communities need cultural mentoring from local community members. (U)

AHWs find that the non Aboriginal health staff do not provide them with enough training with the clinics (U)(R)

Foundational training which includes cultural awareness, mentoring of others, how to navigate the mainstream health system, role definitions and delegation of care responsibilities.

Professional factors: Empowering and enabling the AHW workforce and various health professional workforces to work collaboratively within interprofessional partnerships.

AHWs see value in white workers upskilling in cultural awareness training. (C)(R)

Ensure adequate orientation. (C)

Health professionals working in organisations employing AHWs need education on the role of AHWs. (U)(R)

Lack of a formal orientation program for new AHWs poses difficulties for the non Aboriginal staff. (C)

Non Aboriginal health professionals need cultural respect training. (U)

Non Aboriginal staff need access to information on indigenous learning pedagogy's to facilitate effective learning in the workplace. (U)

Not providing staff with cultural awareness training was seen as a barrier to building good relationships with the Aboriginal community and workers. (U)(R)

Nurses struggle delegating care to non nurses. (C)

AHWs experience a lack of consistency and support at a management level. (U)

AHWs experience paternalistic attitudes from supervising professionals. (U)

AHWs experience problems when supervised by members of other health disciplines. (C)

AHWs prefer to be managed by Aboriginal staff. (C)

Managers of Aboriginal staff are familiar and competent in culturally sensitive management practices.

Professional factors: Empowering and enabling the AHW workforce and various health professional workforces to work collaboratively within interprofessional partnerships.

AHWs report the need for non Aboriginal managers to have cultural respect training. (U)

Culturally insensitive management practices lead to AHWs resigning. (U)

Ensure AHWs are in a work environment that understands traditional Indigenous cultural obligations. (C)

Ongoing cultural awareness training is essential for non Aboriginal managers of Aboriginal staff. (U)

Poor management practices impact on the AHWs enjoyment at work. (C)

Supportive management practices contribute to AHW satisfaction at work. (C)

AHWs don't like working in isolation. (U)

AHWs find networking with other AHWs beneficial. (U)

AHWs need to have formal opportunities to network with each other. (U)

Difficult to perform the AHWs role. (U)

Feelings of isolation, and wanting to connect with other Aboriginal workers. (U)

Importance of networking with Aboriginal staff. (U)

Link AHWs to other Aboriginal staff in the organisation. (C)

Opportunities for AHWs to network and support each other in their respective roles.

Professional factors: Empowering and enabling the AHW workforce and various health professional workforces to work collaboratively within interprofessional partnerships.

Building relationships is key to working with the Aboriginal community. (U)

Clients benefited from caregivers who knew their story. (U)

Clients feel comfortable not having to explain complex social issues. (U)(R)

Clients valued the personal relationships with caregivers. (C)

Health professionals need to be available on a daily basis. (U)

High workloads can impact on effective relationships. (C)

Importance of continuity of caregiver. (U)

Informal processes are an important strategy for engaging with Aboriginal clients. (C)

It takes more time for a health professional to work inter-culturally. (U)

Aboriginal clients looking forward to appointments. (U)

Open communication exists in professional partnerships. (U)

Relationship building happens informally. (U)

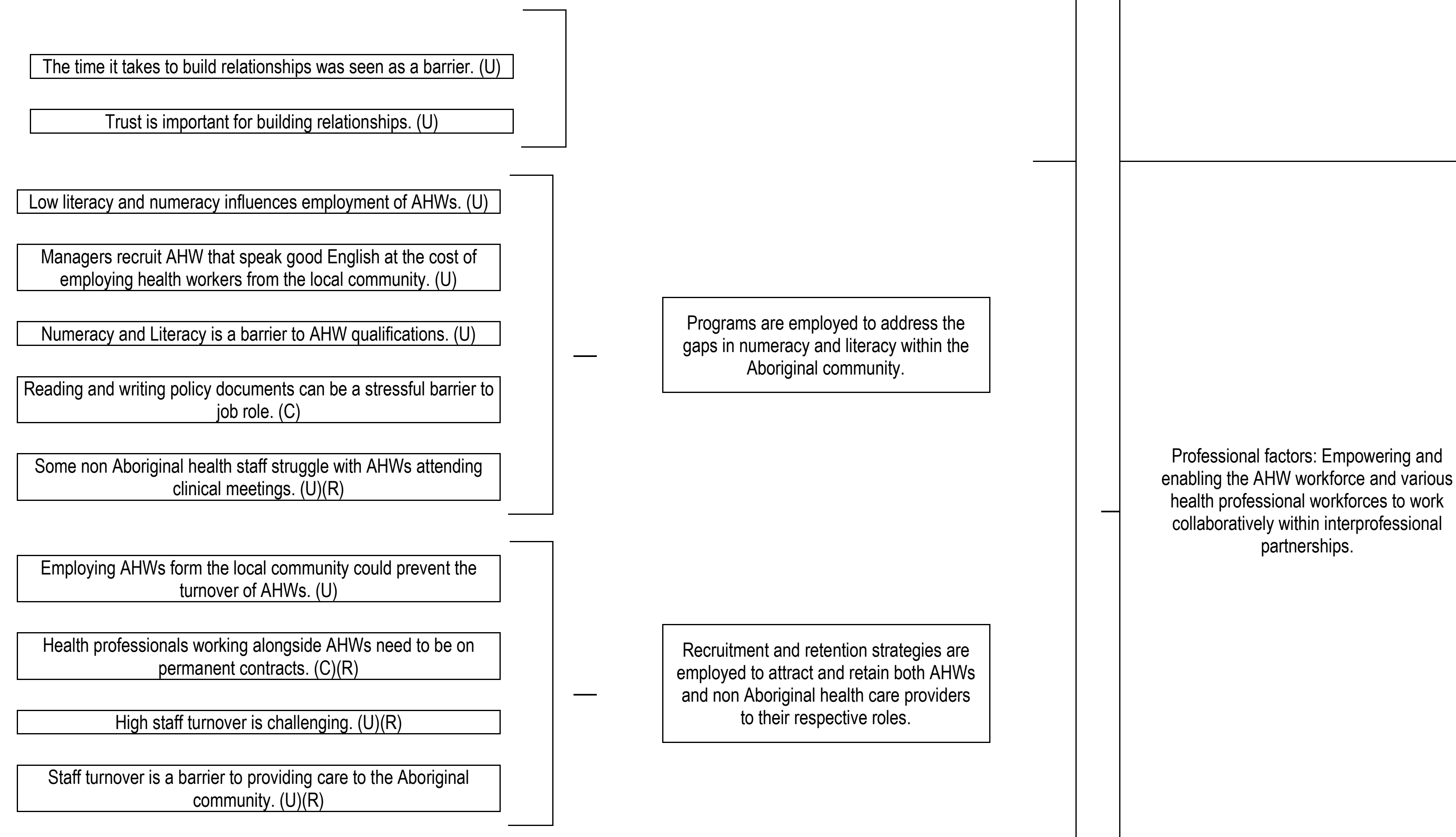
Relationship building in the workplace needs to occur on an informal basis. (U)

Relationship building is an enabler to working with Aboriginal people. (U)

Relationships and trust take time to build. (U)

Program delivery gives consideration to the time it takes to build and maintain positive relationships between non Aboriginal health care providers, AHWs and Aboriginal Australians.

Professional factors: Empowering and enabling the AHW workforce and various health professional workforces to work collaboratively within interprofessional partnerships.

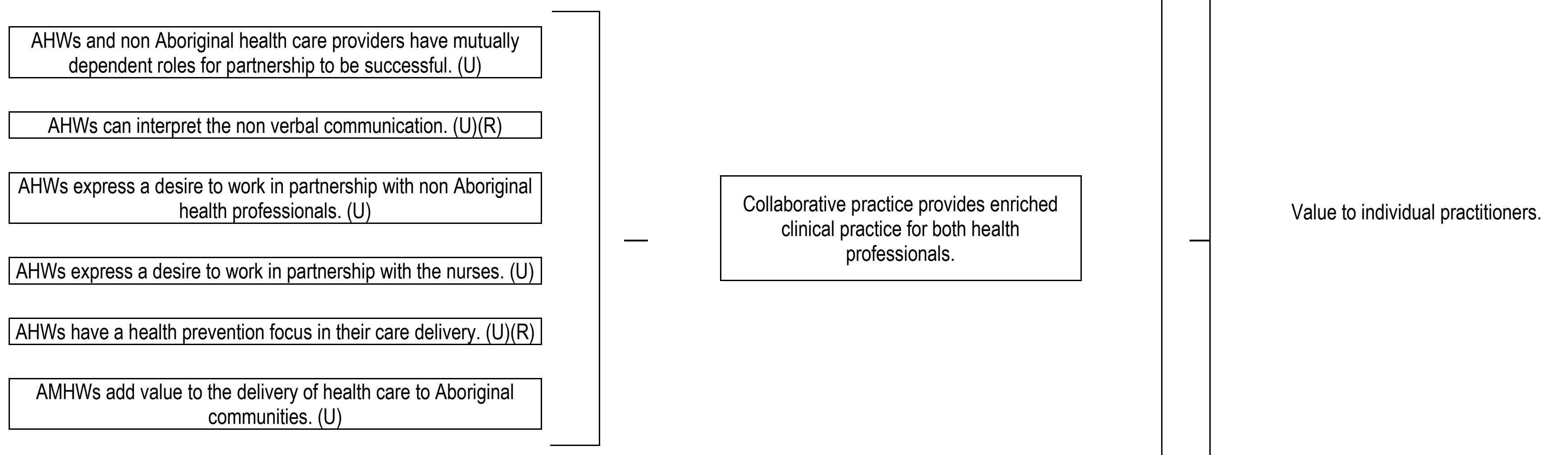


The time it takes to build relationships was seen as a barrier. (U)
Trust is important for building relationships. (U)
Low literacy and numeracy influences employment of AHWs. (U)
Managers recruit AHW that speak good English at the cost of employing health workers from the local community. (U)
Numeracy and Literacy is a barrier to AHW qualifications. (U)
Reading and writing policy documents can be a stressful barrier to job role. (C)
Some non Aboriginal health staff struggle with AHWs attending clinical meetings. (U)(R)
Employing AHWs form the local community could prevent the turnover of AHWs. (U)
Health professionals working alongside AHWs need to be on permanent contracts. (C)(R)
High staff turnover is challenging. (U)(R)
Staff turnover is a barrier to providing care to the Aboriginal community. (U)(R)
Programs are employed to address the gaps in numeracy and literacy within the Aboriginal community.
Recruitment and retention strategies are employed to attract and retain both AHWs and non Aboriginal health care providers to their respective roles.
Professional factors: Empowering and enabling the AHW workforce and various health professional workforces to work collaboratively within interprofessional partnerships.

Synthesised Finding Five

The fifth synthesis relates to the value experienced by individual AHWs and non Aboriginal health care providers when working collaboratively to deliver clinical care. It is an aggregation of five categories informed by 49 findings.

Synthesis five: Value to individual practitioners: It is acknowledged that both AHWs and non Aboriginal health care providers alike gain knowledge and skills from each other when working in collaborative interdisciplinary practice. Effective partnership creates an environment for two way learning, particularly in relation to elements around the clinical, cultural and health promotional paradigms of health care delivery, which appear to provide a mutual benefit to both the AHW and the non Aboriginal health care provider on a personal and clinical practice level.



Non Aboriginal health care providers view AHWs as having strengths in wellbeing work. (U)

Collaboration provides a holistic service for clients. (U)(R)

Cultural benefits are observed for the women and extended Aboriginal community. (U)

Employing AHWs benefits both clients and health professionals. (U)

Health professionals are reliant on AHWs to share their cultural expertise. (U)

Successful partnerships between AHW and non Aboriginal health care providers have positive benefits for the Aboriginal community. (U)

The AHW is placed in a situation of balancing a western medicine approach to treatment with a traditional approach to treatment. (U)(R)

The care is shared between health professional and AHW, relieving the load for the health professional. (C)

The clinical skills of AHWs were viewed positively. (U)

Two way learning is an essential element to partnership. (U)

Two way learning occurs for both the AHW and non Aboriginal health care provider. (U)(R)

Working partnerships enabled White workers to develop an awareness of White privilege. (U)(R)

Aboriginal specific positions enable non Aboriginal health professionals to develop skills in primary health care. (U)

AHWs and non Aboriginal health professionals need to work together on preventative health issues. (U)

AHWs need provision of clinical training in order to support the clinical component of the AHW role. (U)

AHWs practice under a holistic view of health. (U)

AHWs see the patient as a whole person and not a disease. (U)(R)

AHWs see value in working from a primary health care perspective. (U)(R)

Non Aboriginal health care providers lack the skills and experience to support AHWs in implementing community development work. (U)

Non Aboriginal health care providers struggle providing care that is not delivered in the clinical paradigm in which they have been trained. (U)

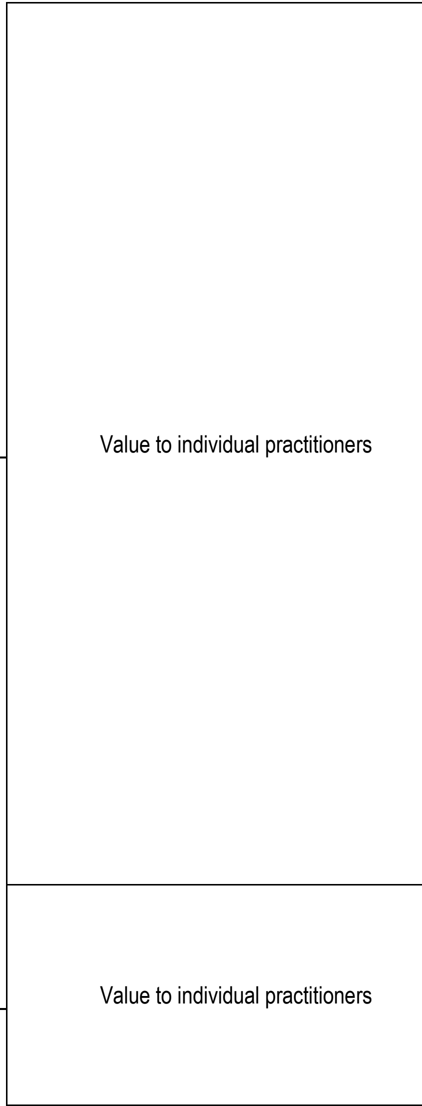
AHWs utilise holistic approaches to deliver care. (U)(R)

Development of skills in health promotion and prevention: this view of health encompasses a more holistic approach to health care which is not fully embraced or acknowledged in other health care teams.

Clients trust the non Aboriginal health professional if they see a good relationship between them and the AHW. (U)(R)

The presence of an AHW, enabled clients to interact more with non Aboriginal staff. (C)

Feelings of trust between the patient and non Aboriginal health care provider can develop after patient sees a respectful partnership between AHW and non Aboriginal health care provider.



The relationship between the AHW and client is transferred to the health care provider. (U)

Trust is transferrable. (U)

Trust is transferred from the AHW to the health professional. (U)

AHWs assist health professionals in navigating Aboriginal culture. (U)

AHWs assist non Aboriginal health care providers to understand the cultural elements relating to a clients illness. (U)

AHWs assist health professionals to provide culturally appropriate interventions. (U)

AHWs believe that for White people to be successful in their work with the Aboriginal community they need cultural awareness. (U)

AHWs bring cultural insights to the health professional. (U)

AHWs have a cultural scope of practice complementing a clinical scope. (U)

AHWs increase health professionals understanding of Aboriginal culture. (U)

AHWs see value in white workers upskilling in cultural awareness training. (C)(R)

AHWs share information with health professionals to increase their understanding of Aboriginal culture. (U)(R)

It is acknowledged that the AHW is able to provide cultural mentoring for non Aboriginal health care providers

Value to individual practitioners

Two way learning occurs for both the AHW and non Aboriginal health care provider. (U)(R)

Working partnerships enabled White workers to develop an awareness of White privilege. (U)(R)

AHWs rely on health professionals to teach clinical knowledge in order to do their role properly. (U)

Community members believe that the non Aboriginal health staff should be delivering more training to the AHW. (U)

Health professionals can provide technical skills mentoring to AHWs. (U)

Health professionals have a role in developing the clinical skills of AHWs. (U)

Non Aboriginal staff should be taking an active role in encouraging AHWs to learn new skills. (U)

There is no support or emphasis on the teaching role that non Aboriginal staff have when working with an AHW. (U)

It is acknowledged that the non Aboriginal health care provider is able to provide clinical mentoring to the AHW.

Value to individual practitioners.

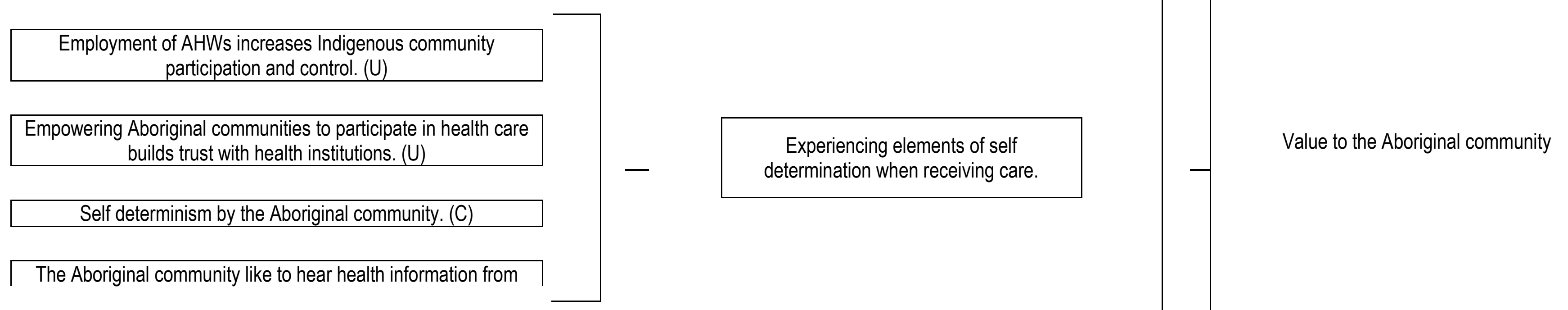
Synthesised Finding Six

The sixth synthesis relates to the value experienced by the Aboriginal community when AHWs and non Aboriginal health care providers work collaboratively to deliver clinical care. It is an aggregation of five categories informed by 60 findings.

Synthesis 6: Value to the Aboriginal community.

Health services are more responsive to the needs of the Aboriginal community members when accessing care, and promote gains in reducing the health inequity facing Aboriginal Australians. Care delivery that involves an AHW, appears to be inclusive of an Aboriginal definition of health, which includes connection to culture and country, and has a health promotional ideology. Care delivered in partnership with an AHW fosters feelings of self determinism in the Aboriginal consumer, increasing the individuals engagement with and control over the services on offer, and adds to an overall feeling of cultural safety when receiving care**.**

Finding	Category	Synthesised Finding



people within their community (U)(R)

The AHW workforce is an important strategy for Aboriginal communities to self determine their own health outcomes. (C)

AHWs help overcome cultural barriers. (C)

AHWs approach health care with a health promotional view. (C)(R)

AHWs are vital for health service delivery to Aboriginal communities. (U)(R)

AHWs employ cultural processes to communicate with their clients. (U)

AHWs help to demystify the hospital experience for clients. (C)(R)

AHWs increased the time available for patient contact due to the extra resource allocation. (C)

AHWs participate in health promotion activities with their communities. (U)

AHWs provide education to Aboriginal clients .(U)

Employing AHWs benefits both clients and health professionals. (U)

The Aboriginal community like to hear health information from people within their community (U)(R)

Health educator to community members: AHWs are an accessible educational resource for patients and their families.

Value to the Aboriginal community

AHW address the Aboriginal social determinants of health. (U)

Health services are able to address the Aboriginal determinants of health, by

Value to the Aboriginal community

AHW observe the social determinants of health impacting on the health status of their community. (U)

AHWs address the social determinants of health for their clients. (C)

AHWs approach health care with a health promotional view. (C)(R)

AHWs experience a holistic view of health. (U)

AHWs have a health prevention focus in their care delivery. (U)(R)

AHWs participate in health promotion activities with their communities. (U)

AHWs practice under a holistic view of health. (U)

AHWs see the patient as a whole person and not a disease. (U)(R)

AHWs value autonomy in their roles. (U)(R)

Clients benefit from a more holistic view of care delivery. (C)

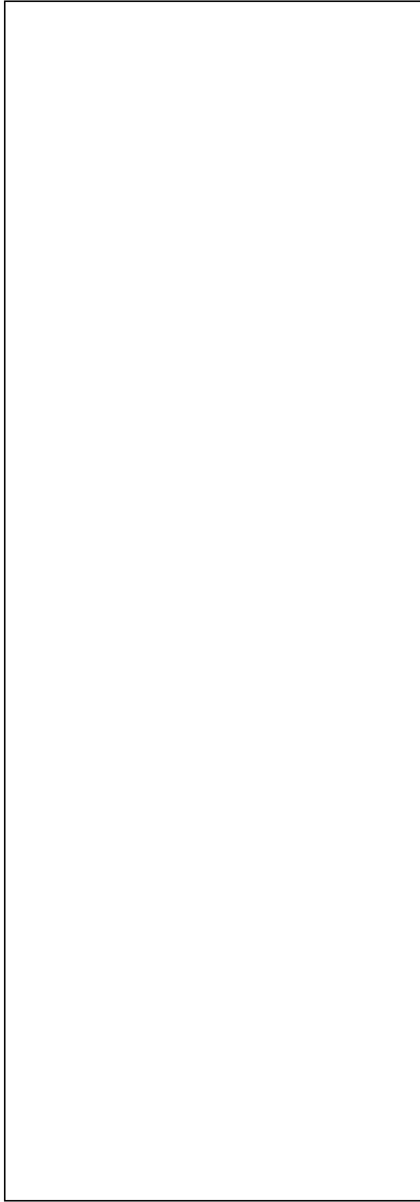
Collaboration provides a holistic service for clients. (U)(R)

AHWs utilise holistic approaches to deliver care. (U)(R)

The AHW is placed in a situation of balancing a western medicine approach to treatment with a traditional approach to treatment. (U)(R)

Western medicine is not inclusive of Aboriginal healing methodologies. (C)

AHW enabling a 'holistic' view of health.



Young women want to learn how to look after their babies from western and Aboriginal perspectives. (U)

AHWs believe that their input in care provides clinical benefits. (U)

AHWs can bring about change in Aboriginal clients health behaviours and attitudes. (U)

AHWs have a function to provide additional information about the client. (U)

AHWs help reduce the incidence of discharge without medical advice(DAMA). (U)(R)

AHWs are important for work to occur with the Aboriginal community. (U)(R)

AHWs are able to bring about change to the health inequity facing Aboriginal Australians. (U)

AHWs are motivated by wanting to make a difference to their community members. (U)

AHWs bring cultural insights to the health professional. (U)

AHWs reflect on past health inequity to cope with the current work situation. (U)

A successful partnership between AHWs and non Aboriginal health care providers has positive benefits for the Aboriginal community. (U)

Improved health outcomes and health equity for Aboriginal patients.

Value to the Aboriginal community

Aboriginal clients are afraid of hospitals. (U)

Increased feelings of cultural safety when accessing care.

Value to the Aboriginal community

Aboriginal patients prefer Aboriginal staff due to language barriers with English. (U)

Accessing the services with AHWs provided a more intimate experience for the clients. (U)

AHWs assist clients in having a voice. (U)

AHWs cultivate cultural safe health care provision. (C)(R)

AHWs enable Aboriginal patients to overcome communication difficulties with non Aboriginal staff. (C)

AHWs help build the development of trust with care providers and the health care establishment. (U)(R)

AHWs through advocacy, enable Aboriginal families to have a voice in health services. (U)

AHWs assist in providing care to Aboriginal clients who do not speak English as a first language. (U)

AHWs can interpret the non verbal communication. (U)(R)

AHWs ensure cultural appropriateness for the Aboriginal community. (U)

AHWs have cross cultural understanding. (U)

AHWs perform clinical work alongside providing social and emotional support. (U)

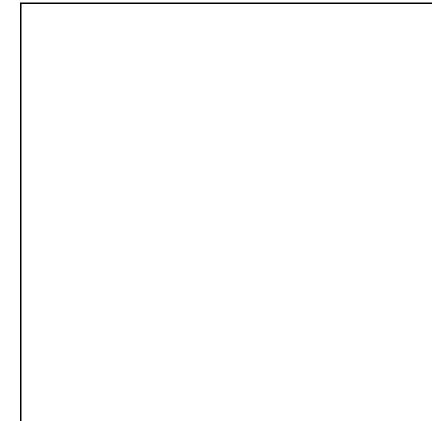
AHWs who can interpret Indigenous languages assist with communication. (U)(R)

Clients feel comfortable not having to explain complex social issues. (U)(R)

Clients trust the non Aboriginal health professional if they see a good relationship between them and the AHW. (U)(R)

Cultural appropriateness of service. (C)

Yarning is a way of making assessments more culturally responsive. (U)



Synthesised Finding Seven

The seventh synthesis relates to the value to the health service and health organisation when AHWs and non Aboriginal health care providers work collaboratively successfully to deliver clinical care. It is an aggregation of three categories informed by 43 findings.

Synthesis Seven: Value to the health service and organisation

Health services are dependent on the employment of AHWs to ensure effective engagement with the Aboriginal communities they service. Hospitals are seen as 'colonialism' to the Aboriginal community, and AHW play a role in informing the health organisation around their cultural responsiveness of health programs, ensuring that they are orientated towards the needs of the Aboriginal community. They also play a role in liaising with the Aboriginal community to ensure that services are meeting local needs and by encouraging and affirming to the community, the quality and cultural safety of the services offered.

Finding	Category	Synthesised Finding
AHWs cultural knowledge is valued by the health professional. (U) AHWs help overcome cultural barriers. (C) AHWs help reduce the incidence of discharge without medical advice (DAMA). (U)(R) AHWs are important for work to occur with the Aboriginal community. (U)(R)	Effective engagement with the community: the role as cultural broker is a feature of the AHW role and extends beyond the health care environment and into the community.	Value to the health service and organisation.

AHWs are seen as important to care delivery process. (C)

AHWs through advocacy, enable Aboriginal families to have a voice in health services. (U)

AHWs are able to advocate for their client to be seen from a holistic view point within health care institutions. (U)

AHWs are vital for health service delivery to Aboriginal communities. (U)(R)

AHWs are vital to service delivery to Aboriginal Australians. (U)(R)

AHWs bridge cultural divides. (C)

AHWs can negotiate the traditional Indigenous and Western health systems. (U)

AHWs employ cultural processes to communicate with their clients. (U)

AHWs ensure cultural appropriateness for the Aboriginal community. (U)

AHWs ensure effective exchange of health information with the Aboriginal client's. (C)

AHWs have a cultural scope of practice complementing a clinical scope. (U)

AHWs have ownership over traditional knowledge systems. (U)

AHWs help improve Aboriginal identification. (C)

AHWs help to demystify the hospital experience for clients. (C)(R)

AHWs need to be from the same cultural community as their clients. (U)(R)

AHWs often are forced to take on an ancillary role in health care setting. (U)(R)

AHWs provide a link to engaging with the Aboriginal community. (U)

AHWs who can interpret Indigenous languages assist with communication. (U)(R)

AMHWs add value to the delivery of health care to Aboriginal communities (U)

Non Aboriginal health professionals see AHWs as a way of connecting and engaging with the Aboriginal community. (U)

Aboriginal communities find health services difficult to access due to cultural barriers. (U)

Aboriginal communities do not trust white dominant health services. (U)

AHWs cultivate cultural safe health care provision. (C)(R)

AHWs help build the development of trust with care providers and the health care establishment. (U)(R)

AHWs increase the accessibility of health services. (U)

AHWs and non Aboriginal health care providers have mutually

Health services offered are seen as more accessible by the Aboriginal community with the employment of AHWs.

Value to the health service and organisation.

dependent roles for partnerships to be successful. (U)

AHWs are fundamental to service delivery. (U)

AHWs are vital for health service delivery to Aboriginal communities. (U)(R)

AHWs are vital to service delivery to Aboriginal Australians. (U)(R)

AHWs make it easier for the Aboriginal community to engage in services earlier. (U)

Employing AHWs increased use in services. (U)

The Aboriginal community is afraid of health institutions. (U)

AHWs acknowledge the diversity across the Aboriginal community. (U)

AHWs are vital for health service delivery to Aboriginal communities. (U)(R)

AHWs cultural knowledge needs valuing. (U)

AHWs enable health services to understand the community they are providing care for. (U)

AHWs have a cultural scope of practice complementing a clinical scope. (U)

AHWs share information with health professionals to increase their understanding of Aboriginal culture. (U)(R)

AHWs value autonomy in their roles. (U)(R)

Increased cultural responsiveness of health organisations, by ensuring services are orientated to the needs of the community.

Value to the health service and organisation.

Chapter 4: Discussion and Conclusions

General Discussion

This review developed seven key synthesised results, four related to the experiences of practitioners working in partnership and a further three related to the enablers and barriers in the work environment that impacted on the experience of partnership. The synthesised findings were developed from strategies and experiences reported by the participants that related to successful collaboration and represent a synthesis of ideas generated from the data in this review. It was identified that the experiences of AHWs and non Aboriginal health care providers working in collaborative clinical arrangements are multifaceted and complex. The experience of each partner in the arrangement is heavily intertwined and influenced by the culture and support offered from within the workplace and across the workforces.

I have chosen a diagram to represent these results diagrammatically, as each of these interfaces has constituent parts, which are interrelated so that a change or modification in one area will lead to a change or modification in another. Each circle demonstrates the links between the structures and systems and each part can be explored as an individual player in the context of the whole workplace environment. This diagram also outlines the structure for which the discussion will be presented.

Figure 2. The workplace environment enabling the experience of successful partnership between AHWs and non Aboriginal health care providers

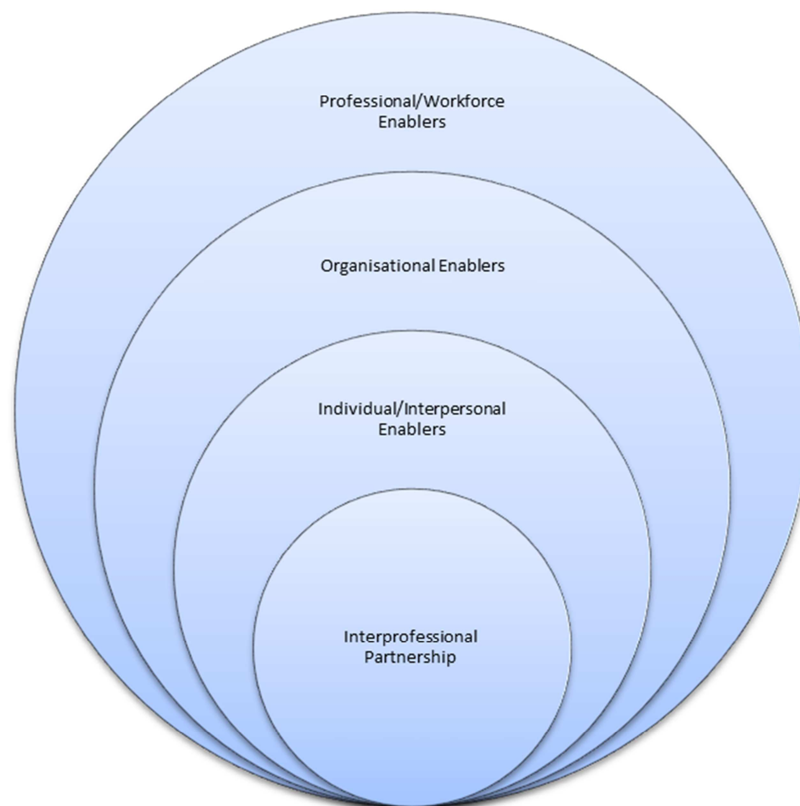


Figure 2 depicts the three levels of synthesised findings that are aimed at enabling and empowering AHWs and non Aboriginal health care providers to experience successful partnership. There are strategies that can be employed at the organisational, workforce and interpersonal level that facilitate a workplace environment that enables the practitioners to experience successful collaboration and form healthy interprofessional partnerships. The remaining four synthesised findings relate to these experiences.

Successful Interprofessional Partnership

The impact of AHWs and non Aboriginal clinicians working collaboratively to deliver care to Aboriginal clients in the primary health care setting is evident. These benefits can be observed in the three synthesised findings, relating to the themes around benefit to the practitioner, benefit to the health service, and benefit to the Aboriginal community.

AHWs when partnering with non-Indigenous health providers, brings complementary skills together(2, 16, 32, 36, 38)to improve the health care available to Aboriginal clients(8, 16, 30, 32, 35, 38), and to decrease the cultural and communication barriers in delivering such health care(8, 16, 30-32, 34, 35, 38). There are a number of barriers identified facing ATSI people when accessing health care. The main barriers being: lack of cultural safety and experiences of racial discrimination, communication barriers, transport issues, and the costs of receiving health care(16). Health services that employ models of care that facilitate partnerships between AHWs and other health providers help address the health inequity facing ATSI communities by ensuring effective delivery of health serves that are matched to the community's needs(8, 16, 29, 30, 32, 34-36, 38).

The synthesised finding, themed around negative experiences, reports negative experiences from both the AHW and non Aboriginal health care provider. The negative experiences have been related to mutual confusion about each other's roles and responsibilities in the collaboration(2, 16, 30, 32, 36), resulting in each professional group feeling threatened or undermined by the perceived role of the other(2, 29, 38). Another common theme across the two professional groups was that of feeling ill prepared to practice in a professional partnership due to lack of training and support around their mentoring roles(2, 8, 29, 32, 36), time restraints or high clinical demands in the workplace(16, 29, 32, 36, 38), and lack of workplace continuity to build effective relationships(16, 29, 32, 36, 38). It is vital that these issues are resolved, as both professional groups, have an important and complimentary role to play in the delivery of health care to Aboriginal Australians.

The diverse skills and responsibilities of AHWs, which included clinical, health promotion, education and leadership roles emerged in the findings(16, 29, 30, 32-34, 36, 38). The increasing recognition of the role of AHWs in providing cultural mentorship for non-Indigenous colleagues is also discussed(16, 30, 32, 36, 38). Despite this AHWs reported experiencing frustration and feelings of shame with situations where they not used effectively within multidisciplinary teams(8, 16, 29, 32, 38), restricting their potential impact in improving health outcomes. Other authors describe the concept of shame used by Aboriginal English

speakers as being broader than the non-Indigenous use of the word[40]. The meaning of shame extends to include embarrassment in certain situations and is often due to attention or circumstances rather than as the result of an action by oneself[40]. The feeling of shame can totally overwhelm and disempower a person.

AHWs also reported strongly that they felt unable to deliver care in a holistic manner congruent with an Aboriginal definition of health, and that holistic care was not valued by the non Aboriginal workforces or health organisation[16, 29, 32, 38]. This finding aligns with reports from other authors and provides some insights into what constitute culturally safe care;

> "There was no separate term in Indigenous languages for health as it is understood in western society. The traditional Indigenous perspective of health is holistic. It encompasses everything important in a person's life, including land, environment, physical body, community, relationships and law. Health is the social, emotional, and cultural wellbeing of the whole community and the concept is thus linked to the sense of being indigenous"[41].

AHWs reported feeling strong tensions between the western medical framework and the ATSI conceptualisation of health, which resulted in the AHWs not being able to implement health initiatives around illness prevention and community development with their people[29, 32, 37, 38]. Similarly, non Aboriginal health professionals felt ill prepared to support AHWs with this aspect of their role whilst training, as they reported knowledge gaps around primary health care[16, 29, 32], or clinical demands which limited their time to focus on the curative activities rather than illness prevention initiatives with the community.

The important relationship between a primary health care approach and a holistic view of health is also described by other authors and highlighted by The National Aboriginal Community Controlled Health Organisation (NACCHO) who describes its commitment to primary health care in the following way:

> "Primary health care' has always been a continuing integral aspect of our Aboriginal life, and is the collective effort of the local Aboriginal community to achieve and maintain its cultural wellbeing. Primary health care is a holistic approach which incorporates body, mind, spirit, land, environment, custom and social-economic status"[18].

AHWs require scope within their work environments that facilitate their ability to deliver care holistically, and the ability to work with their communities to improve the social and environmental conditions of their communities. Within the Aboriginal context, culturally safe health care reflects a holistic approach to health and contains notions of cultural security and cultural respect(16, 29, 32, 38).

Some ATSI health workers participants in this review, reported the workplace as being a culturally unsafe(16, 29, 32) and often disabling environment(16, 29, 30, 32) that does not empower them to contribute effectively to the health care team.

Various other authors have described cultural safety as "the effective care of a person/family from another culture by a health care provider who had undertaken a process of reflection on their own cultural identity and recognises the impact of the health care professional's culture on their practice. Unsafe cultural practice is any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual"(18). The Australian Human Right Commission, advocates that those who work with ATSI people, to move beyond cultural awareness to one of cultural security whereby "it shifts the emphasis from attitudes to behaviour, focussing directly on practice, skills and efficacy. It is about incorporating cultural values into the design, delivery and evaluation of services"(18).

For AHWs to feel culturally secure in the workplace they need to be placed within environments where they can effect change and feel empowered to do so(16, 29, 32, 37, 38).

The AHWs in this review also reported difficulties with balancing the communities expectations and expectations of the health organisation(2, 29, 32, 33, 36). These included the difficulties encountered when working within their own kinship networks and the need to constantly negotiate personal and professional boundaries, which resulted in emotional/compassion fatigue(16, 31-33, 36).

The AHWs in this review also reported frustration with issues related to limited ATSI health worker professional development(8, 16, 29, 32), mainly due to lack of support from health services for accessing ongoing education, training and mentoring.

Several undercurrents between the two professional groups, emerged in the data analysis of the above four synthesised findings relating to the experience of partnership. Non Aboriginal health care providers reported the value of AHWs to both their practice, Aboriginal community and the health

service[8, 16, 29, 32, 35-38]. However this notion was mostly invisible to the AHWs who still felt underappreciated and underutilised in their roles[16, 29, 32].

AHWs reported experiencing no sense of agency to impact the system that they worked within[16, 29, 32, 36] when attempting to make the health service align with the Aboriginal communities health needs and expectations. Despite this it was clear that the non Aboriginal practitioners and health services management viewed this as an essential component of the AHW role, and a component highly valued by both practitioners and health services and the Aboriginal community[8, 16, 29, 32, 36, 38].

The ability to promote two way learning across the professional disciplines seemed a vital attribute to both workers feeling that the partnership was valuable[2, 8, 16, 29, 30, 32, 34, 35, 37, 38]. Two way learning occurred when health workers where in a position to mentor clinicians around culture, and clinicians being able to mentor AHWs around clinical skills. However both partners reported feeling underprepared in skills to mentor and supervise others[16, 29, 32, 36]. From the AHW perspective there was an additional feeling of being disempowered to perform this aspect of their role as they felt in an 'unequal' position to their partner[2, 16, 29, 32, 36]and therefore felt not in a position to do so.

These opposing views can undermine the capacity of individual ATSI health workers and non Aboriginal health care providers to do their job effectively in a collaborative role.

Organisational Enablers

Through examining the experiences of AHWs and clinicians working in collaborative clinical arrangements, these experiences are illuminated as being multifaceted and complex. The experience of each partner in the arrangement is heavily intertwined and influenced by the culture and support offered from within the workplace. Strategies proposed at this level included ensuring culturally safe work environments[16, 31, 32, 34], culturally awareness amongst managers of Aboriginal staff[16, 29, 31, 32] and an organisational culture that values interdisciplinary collaboration[16, 29, 32, 37]. Organisations that also actively sort Aboriginal participation in higher decision making[16, 29, 32, 36, 37] and consultation with the Aboriginal community it serves was also evident as a strategy. There also needs to be an appropriate work space conducive of culturally safe and respectful care where AHWs and clients can go to reconnect with culture and feel safe[29, 31, 33]. The organisation also needs to ensure that the program or model of care that utilises the AHW and the non Aboriginal health care provider is adequately resourced including appropriate staffing levels[16, 29, 30, 32], and funding for essentials in service provision

such as transport[16, 29] and training for staff[2, 32]. A key theme emerging was the importance of adequate time for relationship building amongst non Aboriginal staff and Aboriginal staff and clients[16, 31, 32, 34, 38]. This needed to occur in an informal manner[16, 31, 32, 35, 38] to be effective and requires workplaces to take this into consideration when factoring time in clinical duties.

Professional/Workforce Enablers

The emergence of the AHW role as a successful contributor in improving Aboriginal health outcomes is relatively new in the mainstream literature, and models of care involving collaboration between clinicians and AHWs are starting to emerge. Consequentially, there are workforce perspectives and initiatives that have not yet matured to support these collaborations. AHWs require valuing and acknowledging in their own right[2, 8, 16, 31, 32, 38] which will be achieved through accredited training curriculum, and nationally aligned award wages acknowledging the importance and professional status of their role[16, 29, 32, 38]. Non Aboriginal health professionals also need preparing for their role working alongside AHWs and include strategies such as preparation in understanding each other's role[2, 8, 16, 29, 32], confidence around delegation of clinical care[2, 29, 30, 32, 33, 35, 36], and guidance in mentoring of others [2, 16, 29, 31-33]. AHWs cannot achieve the health outcomes for Aboriginal Australians in isolation, without collaborating with other health professionals. Both professional groups need to work together, this is facilitated by participating in each other's training[16, 32, 36] and mentoring each other's professional development. AHWs experience high levels of emotional labour in their roles[16, 29, 32, 33], the emotional attachment to their clients is strong as they are often members of their own community, and many AHWs reported community backlash from the community when the communities expectations regarding care were not reached[16, 29, 32, 33]. Appropriate mechanisms for debriefing opportunities either through connecting with other Aboriginal workers[16, 29, 31-33, 36] or strong cultural and professional supervision provisions[16, 32, 33] were seen as fundamental in building resilience against emotional burnout.

Interpersonal Enablers

This review also uncovers some of the complex interpersonal skills and qualities of each practitioner required to make the working partnership successful. There are challenges faced by AHWs when negotiating the interface between health service provision and culturally responsive care provision[2, 29, 31-33]. A quality AHW/non Aboriginal health care professional partnership provides a buffering effect for the challenges faced by the AHW when working in the sometimes 'unfriendly' 'white' health care environment. Non Aboriginal health care providers who critically reflect on their own 'whiteness'

become aware of how they have been shaped by a position of privilege[2, 16, 29, 32] and also become aware of the systemic issues in the workplace that impact on Aboriginal workers[16, 29, 32, 38]. The concept of 'whiteness' raised by the AHWs in this review, also aligns with reports of Whiteness theory or studies[32], commented on by other authors. This area of sociological study refers to a specific area of race studies where race is critiqued in terms of the dominant, White culture. A leader in this area is Ruth Frankenberg (1957-2007)[32], who describes 'whiteness' as (a) a location of structural advantage/ race privilege, (b) a standpoint from which White people look at themselves, others and society and (c) a set of cultural practices that are usually unmarked and unnamed[32]. Essentially, the cultural values of the non Aboriginal health care provider can unintentionally make them say or do things in cross cultural interactions that are perceived as intentional[1]. Health care providers who are aware off and successfully navigate their position of whiteness when interacting with Aboriginal people are aware of the direct connection between power relationships and communication that can result in fear, suspicion and mistrust[1]. This provides opportunity to identify where they place themselves in relation to the cultural safety of their practice when working with an Aboriginal person[2, 16, 32, 38] be it a client or AHW. This is fundamental to the AHW feeling culturally safe in the work environment.

In order for a strong and supportive partnership to develop between an AHW and a non Aboriginal health care provider, there needs to be a mutual valuing of and respect for each other's roles[2, 16, 29, 32, 35, 37, 38], and a mutual commitment to improving the health of the Aboriginal community[2, 8, 16, 32, 35, 37, 38]. There also needs to be a belief and desire to work in models supporting collaboration between AHWs and non Aboriginal health care providers[2, 16, 32, 38].

Implications for Practice

The results of this systematic review indicate there are three systems interacting with each other within a health care environment that all play a role in enabling the quality of interpersonal relationships between AHWs and non Aboriginal health care providers. Strategies implemented at each of these levels can individually and collectively enable successful partnerships forming between non Aboriginal health care providers and AHWs. These are strategies that can be employed at the organisation/system level, the workforce level and at the interpersonal level. To some extent, the potency of each of these interventions is reliant on the presence of other aspects being present within the other levels to enable maximum benefit, reflecting the interwoven complexity and nature of the workplace. This systematic review points to several recommendations for practice, which will enhance

the formation of collaborative working partnership between AHW and non Aboriginal health care provider. The grading of each recommendation is based on the JBI Grades of Evidence. See Appendix VIII : JBI Grades of Evidence.

Findings from this review showed that:

- AHWs need scope within their roles to provide health care delivery that does not focus solely on the biomedical needs of their Aboriginal client's but also the cultural, social and preventative health needs of the Aboriginal community. Health organisations and the non Aboriginal health workforce will need to enable the AHW to lead the direction of care delivery around a more holistic and cultural responsive definition of health and facilitate health care delivery that is health promotional in nature. [Grade B evidence].
- AHWs need access to quality training that is aligned with clearly articulated career development pathways, that is adequately resourced, and delivered by a locally accessible educator, to promote the professional status of the role. Training institutions need clear lines of communication with the health care service employing the AHW to ensure opportunities in the workplace are provided, that enables the AHW to translate what has been learnt into their practice. [Grade A evidence].
- AHWs and non Aboriginal health care providers need adequate supports when embarking on collaborative models of care, which includes training in understanding each other's roles, clarity around delegation of care, skills in mentoring and cultural supervision and cultural competency development. Cultural competency development for the non Aboriginal health professional needs to be broadened to also include awareness raising around some of the issues in the workplace that create challenges for Aboriginal staff in the organisation. [Grade A evidence].
- Aboriginal engagement in health service planning, decision making and organisational change, which builds the capacity of AHWs to impact care delivery in a way that improves health outcomes for the Aboriginal community is fundamental in improving the recruitment and retention of AHWs. [Grade A evidence].
- AHWs require access to regular debriefing and cultural supervision which allow the AHWs to successfully gain support for both managing their professional, personal and cultural obligations attached to their roles, which will help prevent the high burnout rates in this workforce. Regular debriefing could include opportunities where the AHW workforce network and collaborate with other AHWs working in the same health organisation, or local area.

Access to an Aboriginal mentor or supervisor, that is not a workplace manager, can also facilitate this supervision. [Grade A evidence].

- AHWs need access to a designated culturally appropriate workspace, where they can retreat and refresh from the burdens of balancing the cross cultural demand associated with their work environment, where they can connect with other Aboriginal staff, and where they can meet with clients and build relationships. This workspace, needs have visual representations of Aboriginal culture in the area, such as Aboriginal artwork, Aboriginal specific health resources, and ATSI flags on display. [Grade B evidence].

Implications for research

Generally, more qualitative studies should be conducted to explore strategies which enable Aboriginal Australians to feel more comfortable in both accessing primary care services and working in primary health care services. Qualitative research that also highlights how non Aboriginal health care providers become aware of issues of power and their role of 'whiteness' and how this compromises the health care provided to Aboriginal Australians is also important. When this is known, non Aboriginal health care providers can be adequately prepared for their roles working in a cross cultural environment. The impact of involving Aboriginal health professionals such as AHWs also needs evaluation in reference to the long term improvements to clinical practice and health outcomes to ensure that the workforce is supported in its development.

Conflict of Interest

Nil reported

Conclusions

Workplace culture and environments impact on the experiences of Aboriginal Health Workers and Non Aboriginal health care providers working in collaborative clinical arrangements. When Aboriginal Health Worker's and Non Aboriginal health care providers are empowered to work in a successful clinical partnership, through an enabling workplace, there is a great benefit for the health professional and Aboriginal Health Worker, the Aboriginal community and the health service. When the workplace is a disabling environment to successful interprofessional partnership, this undermines the capacity of the Aboriginal Health Worker and non Aboriginal health care provider to perform their roles within a

partnership, resulting in negative experiences for the Non Aboriginal health care provider, Aboriginal Health Worker and Aboriginal client.

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Appendices

Appendix I: Detailed Search Strategy

CINAHL Logic GRID

Aboriginal	Australia	Health Care
MH Indigenous Health TI Indigenous Health AB Indigenous Health TW Indigenous Health MH Aborigines MH Indigenous Peoples TI Indigenous Peoples MW Indigenous Peoples TI Aborig* AB Aborig* MW Aborig*	MH Australia MW Australia* AB Australia* TI Australia* AB Victoria TI Victoria AB Queensland TI Queensland AB new south wales TI new south wales AB Tasmania TI Tasmania AB Northern Territory TI Northern Territory	MH community health worker+ TI health worker* AB health worker* MW health worker* MH cultural competence+ AB cultural competence TI cultural competence MH health services* TI health services* AB health services* MH health Care Delivery+ AB health care delivery* TI health care delivery* MH health promotion+ AB health promotion* TI health promotion* TI cultural safety AB cultural safety TI empowerment AB empowerment

CINAHL Search and results

"(MH "Indigenous Health" OR TI "Indigenous Health" OR AB "Indigenous Health" OR TW "Indigenous Health" OR MH Aborigines OR MH "Indigenous Peoples" OR TI "Indigenous Peoples" OR AB "Indigenous Peoples" OR MW "Indigenous Peoples" OR TI Aborig* AB Aborig* MW Aborig*) AND (MH Australia OR MW Australia* OR AB Australia* OR TI Australia* OR AB Victoria OR TI Victoria OR AB Queensland OR TI Queensland OR AB "new south wales" OR TI "new south wales" OR AB Tasmania OR TI Tasmania OR AB "Northern Territory" OR TI "Northern Territory") AND (MH "community health worker+" OR TI "health worker*" OR AB "health worker*" OR MW "health worker*" OR MH "cultural competence+" OR AB "cultural competence" OR TI "cultural competence" OR MW "cultural competence" OR MH "health services" OR TI "health service*" OR AB "health service*" OR MW "health service*" OR MH "health Care Delivery+" OR AB "health care delivery*" OR TI "health care delivery*" OR MW "health care delivery*" OR AB "healthcare delivery*" OR TI "healthcare delivery*" OR MW

"healthcare delivery*" OR AB "delivery of healthcare" OR TI "delivery of healthcare" OR MW "delivery of healthcare" OR AB "delivery of health care" OR TI "delivery of health care" OR MW "delivery of health care" OR MH "health promotion+" OR AB "health promotion*" OR TI "health promotion*" OR MW "health promotion*" OR TI "cultural safety" OR AB "cultural safety" OR MW "cultural safety" OR TI empowerment OR AB empowerment OR MW empowerment OR TI nurs* OR AB nurs* OR TI "quality of health care" OR AB "quality of health care" OR MW "quality of health care") on 2012-10-19 01:48 AM" 824 results.

EMBASE Search and results completed 7/10/12#4.3

Search string one yielded 11,803 results and comprised of the following:

'aborigine'/exp/mj OR 'aborigine' OR aboriginal:ab,ti OR aborigines:ab,ti OR 'oceanic ancestry group':ab,ti OR 'indigenous people'/exp/mj OR 'indigenous people'

Search string 2 yielded 695,098 results and comprised of the following:

'australia'/exp/mj OR 'australia' OR aust*:ab,ti OR 'new south wales':ab,ti OR 'northern territory':ab,ti OR queensland:ab,ti OR tasmania:ab,ti OR victoria:ab,ti

Search string 3 yielded 4,982,681 results and comprised of the following:

'health auxiliary'/exp/mj OR 'health auxiliary' OR 'healthcare'/exp/mj OR 'healthcare' OR 'personnel'/exp/mj OR 'personnel' OR 'health care personnel'/exp/mj OR 'health care personnel' OR 'mental health service'/exp/mj OR 'mental health service' OR collaboration:ab,ti OR partnerhship:ab,ti OR 'health care quality'/exp/mj OR 'health care quality' OR 'health promotion'/exp/mj OR 'health promotion' OR 'health service'/exp/mj OR 'health service' OR 'health service':ab,ti OR 'health service, indigenous':ab,ti OR 'empowerment':ab,ti OR 'health promotion':ab,ti OR 'health care facilities and services'/exp/mj OR 'health care facilities and services' OR 'mainstream services':ab,ti OR 'health care':ab,ti OR 'patient care'/exp/mj OR 'patient care' OR 'cultural safety':ab,ti OR 'cultural competence':ab,ti OR 'cultural responsiveness':ab,ti OR 'multidisciplinary':ab,ti

Search String 4 yeilded 3356 results and comprised of the following:

String 1 AND String 2 AND String 3 AND [1985-2013]/py

PUB MED SEARCH completed 19/10/12

Search	Add to builder	Query	Items found	Time
#7	Add	Search **((#5) AND #4) AND #2** Filters: **Publication date from 1985/01/01 to 2012/10/19**	2147	00:23:50
#6	Add	Search **((#5) AND #4) AND #2**	2315	00:22:42
#5	Add	Search **(health services[mh] OR indigenous health service*[tiab] OR cooperative behaviour[mh] OR community health worker[mh] OR primary health care[mh] OR Professional-Patient relations[mh] OR interinstitutional relations[mh] OR health worker*[tiab] OR health worker*[tw] OR cultural competence[tiab] OR cultural competence[tw] OR health service*[tiab] OR health service*[tw] OR health care delivery[tiab] OR health care delivery*[tw] OR healthcare delivery[tiab] OR healthcare delivery[tw] OR delivery of healthcare[tiab] OR delivery of healthcare[tw] OR delivery of health care[tiab] OR delivery of health care[tw] OR health promotion[tiab] OR health promotion[tw] OR cultural safety[tiab] OR cultural safety[tw] OR empowerment[tiab] OR empowerment[tw] OR nurs*[tiab] OR nurs*[tw] OR quality of health care[tiab] OR quality of health care[tw])**	1978824	00:15:01
#4	Add	Search **(australia*[tw] OR victoria[tw] OR new south wales[tw] OR queensland[tw] OR northern territory[tw] OR tasmania[tw] OR australian capital territory[tw] OR australia[mh])**	123861	23:59:56
#3	Add	Search **(australia*[tw] OR victoria[tw] OR new south wales[tw] OR queensland[tw] OR northern territory[tw] OR tasmania OR australian capital territory OR australia[mh])**	127393	23:55:30
#2	Add	Search **(oceanic ancestry group[mh] OR aborig*[tiab] OR indigenous[tiab])**	23952	23:53:54
#1	Add	Search **(((oceanic ancestry group[mh] OR aborig*[tiab] OR indigenous[tiab]) AND (australia*[tw] OR victoria[tw] OR new south wales[tw] OR queensland[tw] OR northern territory[tw] OR tasmania OR australia[mh]))) AND (health services[mh] OR indigenous health service*[tiab] OR Cooperative Behaviour[mh] OR Community Health worker[mh] OR Primary Health Care[mh] OR Professional-Patient Relations[mh])**		

Scopus search and results completed October 2012

TITLE-ABS-KEY("**indigenous Health**" OR **aborigines** OR "**indigenous people**" OR **aborig***) AND (**australia** OR **victoria** OR **queensland** OR "**new south wales**" OR **tasmania** OR "**northern territory**" OR "**Australian Capital Territory**") AND ("**health worker***" OR "**aboriginal health worker**" OR "**cultural competence**" OR "**cultural safety**" OR "**health services**" OR "**health care delivery**" OR "**health promotion**" OR **empowerment** OR "**quality of health care**" OR "**primary care**" OR "**patient care**" OR "**primary health care**" OR **nurs**") AND (LIMIT-TO(PUBYEAR, **2012**) OR LIMIT-TO(PUBYEAR, **2011**) OR LIMIT-TO(PUBYEAR, **2010**) OR LIMIT-TO(PUBYEAR, **2009**) OR LIMIT-TO(PUBYEAR, **2008**) OR LIMIT-TO(PUBYEAR, **2007**) OR LIMIT-TO(PUBYEAR, **2006**) OR LIMIT-TO(PUBYEAR, **2005**) OR LIMIT-TO(PUBYEAR, **2004**) OR LIMIT-TO(PUBYEAR, **2003**) OR LIMIT-TO(PUBYEAR, **2002**) OR LIMIT-TO(PUBYEAR, **2001**) OR LIMIT-TO(PUBYEAR, **2000**) OR LIMIT-TO(PUBYEAR, **1999**) OR LIMIT-TO(PUBYEAR, **1998**) OR LIMIT-TO(PUBYEAR, **1997**) OR LIMIT-TO(PUBYEAR, **1996**) OR LIMIT-TO(PUBYEAR, **1995**) OR LIMIT-TO(PUBYEAR, **1994**) OR LIMIT-TO(PUBYEAR, **1993**) OR LIMIT-TO(PUBYEAR, **1992**) OR LIMIT-TO(PUBYEAR, **1990**) OR LIMIT-TO(PUBYEAR, **1989**) OR LIMIT-TO(PUBYEAR, **1988**) OR LIMIT-TO(PUBYEAR, **1987**) OR LIMIT-TO(PUBYEAR, **1985**))

2,997

6

((TITLE-ABS-KEY("**health worker***" OR "**aboriginal health worker**" OR "**cultural competence**" OR "**cultural safety**" OR "**health services**" OR "**health care delivery**" OR "**health promotion**" OR **empowerment** OR "**quality of health care**" OR "**primary care**" OR "**patient care**" OR "**primary health care**" OR **nurs**")) AND (TITLE-ABS-KEY(**australia** OR **victoria** OR **queensland** OR "**new south wales**" OR **tasmania** OR "**northern territory**" OR "**australian capital territory**"))) AND ((**australia** OR **victoria** OR **queensland** OR "**new south wales**" OR **tasmania** OR "**northern territory**" OR **australian capital territory**)) AND (LIMIT-TO(PUBYEAR, **2012**) OR LIMIT-TO(PUBYEAR, **2011**) OR LIMIT-TO(PUBYEAR, **2010**) OR LIMIT-TO(PUBYEAR, **2009**) OR LIMIT-TO(PUBYEAR, **2008**) OR LIMIT-TO(PUBYEAR, **2007**) OR LIMIT-TO(PUBYEAR, **2006**) OR LIMIT-TO(PUBYEAR, **2005**) OR LIMIT-TO(PUBYEAR, **2004**) OR LIMIT-TO(PUBYEAR, **2003**) OR LIMIT-TO(PUBYEAR, **2002**) OR LIMIT-TO(PUBYEAR, **2001**) OR LIMIT-TO(PUBYEAR, **2000**) OR LIMIT-TO(PUBYEAR, **1999**) OR LIMIT-TO(PUBYEAR, **1998**) OR LIMIT-TO(PUBYEAR, **1997**) OR LIMIT-TO(PUBYEAR, **1996**) OR LIMIT-TO(PUBYEAR, **1995**) OR LIMIT-TO(PUBYEAR, **1994**) OR LIMIT-TO(PUBYEAR, **1993**) OR LIMIT-TO(PUBYEAR, **1992**) OR LIMIT-TO(PUBYEAR, **1990**) OR LIMIT-TO(PUBYEAR, **1989**) OR LIMIT-TO(PUBYEAR, **1988**) OR LIMIT-TO(PUBYEAR, **1987**) OR LIMIT-TO(PUBYEAR, **1985**))

281

5

TITLE-ABS-KEY("**health worker***" OR "**aboriginal health worker**" OR "**cultural competence**" OR "**cultural safety**" OR "**health services**" OR "**health care delivery**" OR "**health promotion**" OR **empowerment** OR "**quality of health care**" OR "**primary care**" OR "**patient care**" OR "**primary health care**" OR **nurs**") AND (LIMIT-TO(PUBYEAR, **2012**) OR LIMIT-TO(PUBYEAR, **2011**) OR LIMIT-TO(PUBYEAR, **2010**) OR LIMIT-TO(PUBYEAR, **2009**) OR LIMIT-TO(PUBYEAR, **2008**) OR LIMIT-TO(PUBYEAR, **2007**) OR LIMIT-TO(PUBYEAR, **2006**) OR LIMIT-TO(PUBYEAR, **2005**) OR LIMIT-TO(PUBYEAR, **2004**) OR LIMIT-TO(PUBYEAR, **2003**) OR LIMIT-TO(PUBYEAR, **2002**) OR LIMIT-TO(PUBYEAR, **2001**) OR LIMIT-TO(PUBYEAR, **2000**) OR LIMIT-TO(PUBYEAR, **1999**) OR LIMIT-TO(PUBYEAR, **1998**) OR LIMIT-TO(PUBYEAR, **1997**) OR LIMIT-TO(PUBYEAR, **1996**) OR LIMIT-TO(PUBYEAR, **1995**) OR LIMIT-TO(PUBYEAR, **1994**) OR LIMIT-TO(PUBYEAR, **1993**) OR LIMIT-TO(PUBYEAR, **1992**) OR LIMIT-TO(PUBYEAR,

1990) OR LIMIT-TO(PUBYEAR, **1989**) OR LIMIT-TO(PUBYEAR, **1988**) OR LIMIT-TO(PUBYEAR, **1987**) OR LIMIT-TO(PUBYEAR, **1985**))

956,673

4

TITLE-ABS-KEY(**australia** OR **victoria** OR **queensland** OR **"new south wales"** OR **tasmania** OR **"northern territory"** OR **"australian capital territory"**)

307,961

3

TITLE-ABS-KEY(**australia** OR **victoria** OR **queensland** OR **"new south wales"** OR **tasmania** OR **"northern territory"** OR **australian capital territory**)

976

2

(**australia** OR **victoria** OR **queensland** OR **"new south wales"** OR **tasmania** OR **"northern territory"** OR **australian capital territory**)

4,570

1

TITLE-ABS-KEY(**"indigenous Health"** OR **aborigines** OR **"indigenous people"** OR **aborig***)

23,199

Appendix II: Results of Critical Appraisal in QARI of included studies

Number of studies included and excluded

Number of studies included	Number of studies excluded
13	13

Final Assessment Table

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Annabelle Wilson, 2011	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Jackson, D., Brady, W., Stein, I. 1999	Y	Y	Y	Y	Y	U	Y	Y	Y	Y
Stamp, G., Champion, S., Anderson, G., Warren, B., Stuart - Butler, D., Doolan, J., Boles, C., Callaghan, L., Foale, A., Muyambi, C., 2008	U	Y	Y	Y	Y	Y	Y	Y	Y	Y
McGrath, P., Patton, M., Ogilvie, K., Rayner, R., McGrath, Z., Holewa, H., 2007	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Taylor, K., Thompson, S., Smith, J., Dimer, L., Ali, M., Wood, M., 2009	N	Y	Y	Y	Y	U	Y	Y	Y	Y
Hooper, K., Thomas, Y., Clarke, M., 2007	N	Y	Y	Y	Y	U	Y	Y	Y	Y
Simmonds, D., West, L., Porter, J., Tangey, A., Davies, M., O'Rourke, P., Holland, C., 2010	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Health Workforce Australia, 2011	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Robinson, G., Harris, A., 2005	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Wilkin, A., Liamputtong, P., 2010	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Hecker, R, 1994	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Homer, C., Foureur, M., Allende, T., Pekin, F., Cplice, S., Catling-Paull, C., 2012	N	Y	Y	Y	Y	U	Y	Y	Y	Y
Logan, G., Blakos, K., 2011	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
%	38.46	100.0	100.0	100.0	100.0	69.23	100.0	100.0	100.0	100.0

Appendix III: Appraisal instrument

QARI Appraisal instrument

JBI QARI Critical Appraisal Checklist for Interpretive & Critical Research

Reviewer ________________________ Date ________________________

Author ________________________ Year _______ Record Number _______

	Yes	No	Unclear	Not Applicable
1. Is there congruity between the stated philosophical perspective and the research methodology?	☐	☐	☐	☐
2. Is there congruity between the research methodology and the research question or objectives?	☐	☐	☐	☐
3. Is there congruity between the research methodology and the methods used to collect data?	☐	☐	☐	☐
4. Is there congruity between the research methodology and the representation and analysis of data?	☐	☐	☐	☐
5. Is there congruity between the research methodology and the interpretation of results?	☐	☐	☐	☐
6. Is there a statement locating the researcher culturally or theoretically?	☐	☐	☐	☐
7. Is the influence of the researcher on the research, and vice- versa, addressed?	☐	☐	☐	☐
8. Are participants, and their voices, adequately represented?	☐	☐	☐	☐
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	☐	☐	☐	☐
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	☐	☐	☐	☐

Overall appraisal: ☐ Include ☐ Exclude ☐ Seek further info. ☐

Comments (Including reason for exclusion)

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Appendix IV: Data extraction instrument

QARI data extraction instrument

JBI QARI Data Extraction Form for Interpretive & Critical Research

Reviewer ______________________ Date ______________________

Author ______________________ Year ______________________

Journal ______________________ Record Number ______________________

Study Description

Methodology

____

Method

____

Phenomena of interest

____

Setting

____

Geographical

____

Cultural

____

Participants

____

Data analysis

____

Authors Conclusions

____

Comments

____

Complete Yes ☐ No ☐

Findings	Illustration from Publication (page number)	Evidence		
		Unequivocal	Credible	Unsupported

Extraction of findings complete Yes ☐ No ☐

Appendix V: Included studies

Study	Methods	Participants	Intervention	Outcomes	Notes
[32], Annabelle Wilson, 2011	41 semi structured interviews with white health professionals and AHWs. One focus group with White health professionals. Utilised Aboriginal reference group.	Aboriginal and white health professionals working on the eat well be active program in one rural and urban community.	Investigates the role of white health professionals in addressing their white privilege whilst working in Aboriginal health.	Organisation, professional and the individual were identified as systems within the wider realm of Aboriginal health. Really unpacks the role of white health professionals in creating and maintaining barriers and enablers	Advocates from the side of the white professional being aware of one's own whiteness.
[2], Jackson, D., Wendy Brady, W. Stein, I. 1999	Audio taped discussion with researchers, which was then transcribed, then participants sent copies of the narrative text and able to delete or modify data before being analysed. Had Aboriginal researcher listed as co author.	4 experienced AHWs. 3 experienced registered nurses, all with a commitment to the process of reconciliation with Aboriginal Australians..	To explore the professional relationships between AHWs and nurses.	Aboriginal health discipline in its own right, must be under control of Aboriginal people. Nurses to extend collegial regard and support to AHWs.	Privileges Aboriginal voice by participants directing research questions. Researchers interviewed participants, one interviewer Aboriginal.
[16], Health Workforce Australia, 2011	Key informant interviews (semi structured) in individual and focus group settings, surveys of health workers and health worker managers and community and site visits for observation and mapping of models. Utilised Aboriginal reference group and Aboriginal co researchers.	Adopted a whole of population approach and had 4 key participant groups. ATSI Health Workers(264 interviewed 351 surveyed), Mangers of ATSI Health Workers(100 interviewed and 100 surveyed), ATSI HW employers and workforce representatives(25 interviewed).	The policies and strategies which strengthen and sustain the AHW workforce to deliver care in response to the known burden and distribution of disease in the ATSI population.	Recognises the importance of AHWs being recognised and empowered in their workplaces to improve health outcomes for ATSI communities. Advocates for a nationally consistent approach across all stakeholders to achieve this. Benefits for the wider population to learn from comprehensive approach to primary health care to tackle chronic disease.	Utilises a key informant group to develop the framework used in the methodology of the project. Unclear reporting on how many participants were Aboriginal on the key informant group. Reports 22 of the 83 key informants came from Aboriginal Community controlled organisations, and 2 of the key informants where AHWs themselves.
[29], Hecker, R, 1994	Unstructured interviews with key informants and	AHWs, non- Anangu health staff, the Nganampa Health	Exploring the factors which prevent AHWs from being	Low literacy and numeracy levels, standard of training,	Author reports time constraints impacted on

	observation in the field Utilised Aboriginal reference group.	Council health committee, members of the Anangu community, past AHWs, education workers.	empowered with the context of Aboriginal control for workers working in the Pitjantjatjara Lands	current structures within the health service and issues of accountability inhibit the empowerment of Aboriginal health workers.	the data collections. Uses a triangulation of data sources ie views from a wide variety of sources to seek correlations in reports. Also, each participant was given transcript of their interview to make additions and corrections before findings were extracted as a means of limiting data bias through eyes of researcher. Did not use Aboriginal researcher in collection of data but used participants as co researchers to define phenomena of interest and help with data analysis.
[34], Homer, C., Foureur, M., Allende, T., Pekin, F., Cplice, S., Catling-Paull, C., 2012	Focus group with ATSI women who had accessed the service was conducted, then tape recorded, then transcribed verbatim and analysed. Aboriginal reference group and co author.	Focus group of local ATSI women who were current or recent users of the service.	Evaluates the perspective of the ATSI women who accessed the Malabar Community Link Service.	The malabar health service is meeting the needs of the community.	Used Aboriginal evaluation group to ensure Aboriginal voice privileged. Unsure if Aboriginal researchers present at focus group. Aboriginal co -authors.
[35], Hooper, K., Thomas, Y., Clarke, M., 2007	Descriptive qualitative design. Two phased research methodology. Phase one was a questionnaire and information package sent to all occupational therapists and AHWs practicing in rural and remote areas of North Queensland. Phase two was in-depth semi structured telephone interviews which were recorded. Utilised Aboriginal reference group.	Four occupational therapists and three AHWs, all female.	The extent and nature of professional partnerships between occupational therapists and AHWs.	Substantiates the necessity for the formation of professional partnerships between occupational therapists and AHWs, to provide positive outcomes for Aboriginal clients and communities.	Aboriginal advisor providing Aboriginal cultural expertise acknowledged by study researchers. Ethics approval from a HREC.

[33], Logan, G., Blakos, K., 2011	Semi structured interviews designed to identify the strategies, skills and qualities used by experienced AHWs in the therapeutic process. Aboriginal cultural reference group.	10 Senior AHWs	Strategies for supporting experienced AHWs are to provide effective healing strategies to their community, working in mental health and drug dependency.	Strategies include culturally safe environment, listening to people's story, having a holistic approach and allowing communities to self determine. Barriers included managing risks and boundaries, working with community, and challenging client behaviours.	Privileges Aboriginal voice by the utilisation of an Aboriginal cultural reference group who ensured appropriate interpretation of results.
[30], McGrath, P., Patton, M., Ogilvie, K., Rayner, R., McGrath, Z., Holewa, H., 2007	Open- ended, qualitative interviews with consumers and health professionals. Utilised Aboriginal reference group to oversee project. All data collection completed by an AHW.	10 Indigenous patients and 19 carers, and 30 health professionals and 11 AHWs caring for them.	Explore the benefits of employing an AHW when providing care in a palliative care context.	AHWs are a valuable resource for palliative care models, and difficult to recruit.	An AHW was a member of the research team and coordinated all communications with Aboriginal participants. Considered views of Aboriginal Liason Officers's as well as AHWs. Strongly privileges Aboriginal voice.
[36], Robinson, G., Harris, A., 2005	Predominantly semi structured interviews with stakeholders, site visits to communities to interview health care staff including Aboriginal Mental Health Workers (AMHWs) and interview mental health clients.	Appears to be 3 mental health nurses, several GP's, seven AMHWs in six different communities, and a number of consumers.	An evaluation of the Aboriginal Mental Health Program. The evaluation focussed the experiences and views of the AMHWs working in the program. It outlines the role of AMHWs and examines the degree with which they felt successfully integrated into clinical practice, with a view of identifying the constraints on development of their role.	The most effective support for AMHWs and the ongoing development and stabilisation of their role is in the health sites that have firm local managerial support.	The Program supports the employment of community based AMHWs to work in partnership with GP's and other health care workers.
[37], Simmonds, D., West, L., Porter, J., Tangey, A., Davies, M., O'Rourke, P., Holland, C., 2010	Guided by the senior Aboriginal women's group attached to study. Unstructured interviews that were transcribed and analysed for themes. Aboriginal co authors.	36 Ngaanyatjarra community women who had birthed at least once in the service, aged between 16 and 83.	The experience of Ngaanyatjarra women accessing the current maternity service.	Western medicine can be adapted to consider cultural elements without compromising safety. Traditional and contemporary birthing knowledge should be shared between community	Privileges Indigenous voice with Aboriginal women's advisory group having strong input to methodology and conferring of analysis. Told from perspective of

				and health practitioners. Stronger connections to culture needed in care delivery.	consumers.
[38], Stamp, G., Champion, S., Anderson, G., Warren, B., Stuart - Butler, D., Doolan, J., Boles, C., Callaghan, L., Foale, A., Muyambi, C., 2008	Semi structured interviews with open ended questions. Questions used at interview developed by two Aboriginal researchers and a midwife. Aboriginal researcher conducted interviews with 5 Aboriginal Maternal Infant Care workers, 4 being taped. Four midwives working on the program were interviewed either face to face or over the phone. Tapes transcribed and returned for comment. Transcriptions were examined by independent Aboriginal researcher and agreement reached on main themes. Aboriginal co authors.	5 part time Aboriginal and Maternal Infant Care (AMIC) workers, 5 part time midwives working within the Anangu Bibi Family Birthing Program.	To investigate aspects of AMIC workers and midwives' working relationships and roles.	Themes relating to partnership for AMIC workers was having mutually equivalent roles, themes relating to partnership for the midwives were time and commitment to working interculturally, issues with the new AMIC worker role, clinical skill sharing and mentoring, resistance of some hospital midwives, respect for AMIC workers cultural knowledge and community links and two way learning.	Strongly privileges Aboriginal voice through research methods.
[8], Taylor, K., Thompson, S., Smith, J., Dimer, L., Ali, M., Wood, M., 2009	Interviews with open ended questions developed by the interview team, which were recorded then transcribed. Aboriginal co authors.	Staff and patients invited to participate. 4 cardiology ward nurses, 2 cardiac rehab nurses, 2 doctors, 2 social workers, 2 AHW recruited to the cardiac unit and 1 AHW, working elsewhere in the hospital. 12 recent Aboriginal cardiac inpatients.	To explore the impact of an AHW on hospitalised Aboriginal experiences in a cardiology area. Looks at perspectives from AHWs, health professionals and clients.	Study demonstrates that AHWs have a significant impact on Aboriginal cardiac inpatient experiences and outpatient care.	Adequately privileges Aboriginal voice. Aboriginal co researcher.
[26], Wilkin, A., Liamputtong, P., 2010	Photo voice and semi structured interviews with participants. Photo voice entails participants taking photos then having an interview with the researcher	Six Australian Indigenous women who were currently working in the health care system in Victoria.	Examination of the experiences of Indigenous women who work in the health care system in Victoria.	Participants found their jobs stressful in relation to the complexity of their clients and the systemic barriers in their workplace. They were passionate about being able in	The photo voice method enabled the 'researched' to impact the types of questions in the interview which may provide voice to the Aboriginal experience.

	answering questions derived from the photo.			effect change in health outcomes for their communities.	

Appendix VI: Excluded studies

Davidson P, DiGiacomo M, Abbott P, Zecchin R, Heal P, Mieni L, Sheerin N, Smith J, Mark A, Bradbery B, Davison J. A partnership model in the development and implementation of a collaborative, cardiovascular education program for Aboriginal Health Workers. Australian Health Review. 2008; 32 (1):139– 46.

Reason for exclusion: Study off scope, more focussed on collaboration for training program, not collaboration for health care delivery.

Dollard J, Stewart T, Fuller J, Blue I. Aboriginal Health Worker Status in South Australia. Aboriginal and Islander Health Worker Journal. 2001; 25(1):28-30.

Reason for exclusion: poor quality study, met 3 of the appraisal criteria.

Grant M,Felton-Busch C, Elston J,, Saunders]V, Crossland L, Solomon S, Payne C. Bulletproofing Indigenous Health Students and Staff Against Racism. Proceedings of the 10th National Rural Health Conference; 2009 May; Cairns, Australia. 10th National Rural Health Conference.

Reason for exclusion: uncertain whether this meets inclusion criteria, lack of data from which conclusions are drawn, no ethics approval.

Harris A, Robinson G. The Aboriginal Mental Health Worker Program: The challenge of supporting Aboriginal involvement in mental health care in the remote community context. Australian e-Journal for the Advancement of Mental Health. 2007; 6(1):15-25

Reason for exclusion: poor quality of reporting, no qualitative data.

Howard D, Lines D, Kelly K, Wing R,, Williams T. Mixed Messages: Cross Cultural management in Aboriginal Community controlled Health services. 2006. Nightcliff, NT: Phoenix Consulting.

Reason for exclusion: methodology used to collect data unclear.

McBain-Rigg K, Veitch C. Cultural barriers to health care for Aboriginal and Torres Strait Islanders in Mount Isa. Australian Journal of Rural Health. 2011; 19(2): 70-74.

Reason for exclusion: off scope, looks at barriers to accessing care from Aboriginal patients perspective.

Millard M, Wilson A. Considering models of practice: challenges faced by the Bush Support Service in developing service delivery to support remote area Aboriginal workers in health. Proceedings of 11th National Rural Health Conference: 2011 March; Perth, Australia. National Rural Health Alliance.

Reason for exclusion: poor quality study, no ethics approval, methodology questionable, no representation of participants voices.

Murphy E, Best E, The Aboriginal Maternal and Infant Health Service: a decade of achievement in the health of women and babies in NSW. New South Wales Public Health Bulletin. 2012; 23(4): 68-72.

Reason for exclusion: data representation incongruent to review objective, data was presented according to model of care rather than exploring the experience of non Aboriginal health care providers/AHWs.

NSW Health, NSW Aboriginal Maternal and Infant Health Strategy Evaluation. Final report. 2005. p. 41.

Reason for exclusion: no examples of data collected from which conclusions drawn.

Shephard M, Mazzachi B,, Shephard A, Burgoyne T, Dufek A, Ah Kit J, Mills D, Dunn D. Point of Care Testing in Aboriginal Hands - A Model for Chronic Disease Prevention and Management in Indigenous Australia. Point of Care. 2006: 5(4): 168 – 176.

Reason for exclusion: lack of data re participants views, unable to determine where conclusions are drawn from.

Si D, Togni S, D'Abbs P, Robinson G. Aboriginal health workers and diabetes care in remote community health centres: a mixed method analysis. Medical Journal of Australia. 2006: 185(1): 40 – 45.

Reason for exclusion: poor quality study, participants voices not adequately represented and does not deal with influence of researcher.

Stathis S, Letters P, Dacre E, Doolan I, Health K, Litchfield B, The role of an Indigenous Health Worker in contributing to equity of access to a mental health and substance abuse service for Indigenous you people in a youth detention centre. Australian e-Journal for the Advancement of Mental Health. 2007: 6(1): 1-16.

Reason for exclusion: qualitative data not adequately presented, lack of data means cant ascertain if the research methods suitable.

Waples-Crowe P, Pyett P, The making of a great relationship: A review of a health partnership between mainstream and indigenous organisations. Victorian Community Controlled Health Organisation Inc. Melbourne. March 2005. P 22.

Reason for exclusion: incongruence between methods to collect data and representation of results. Off scope, focus is on interagency partnership rather than individual practitioner partnership.

Appendix VII: List of study findings / conclusions

Please note that in the following tables, those findings that have been repeated across different categories, thus demonstrated with an (R) in the results, are shaded when presented in the following table.

Wilson A. Addressing Uncomfortable Issues: The role of White health professionals in Aboriginal health. Adelaide: Flinders University; 2011.

Finding1	Humility was raised as an important quality for White professionals.
Illustration	"Part of being humble is accepting that it is okay to make mistakes, being 'prepared to be told off sometimes' and then getting on with it again afterwards." p 207.
Finding2	Reflection and reflexivity engaged in by health professionals.
Illustration	"Despite referring to it as reflection, some dieticians highlighted that they actually engaged in reflexivity through discussing examples of how they had altered their practice based on a reflection" p. 209.
Finding3	Organisational culture is important for enabling White workers to work with Aboriginal people.
Illustration	"Obviously being in the [health service] there's a very strong, good Aboriginal Health team there, you know it is very public in its commitment towards working with Aboriginal people. When you walk in there's those posters about invasion and that sort of stuff and there's groups like [model] so it is very obvious that you need to be working with the Aboriginal community when you are in [health service]" p. 217.
Finding4	AHWs are vital to service delivery to Aboriginal Australians.
Illustration	"They're in a good position for that; I mean we couldn't work with the Aboriginal community if we didn't have our Aboriginal workers." p. 199
Finding5	AHWs provide a link to engaging with the Aboriginal community.
Illustration	"You still have to develop the relationships between ourselves and the community but it is that worker who can supply the link into there" p. 199.
Finding6	Trust is transferred from the AHW to the health professional.
Illustration	"If that worker respects us and we respect them well they' say 'oh

	she's all right, she knows what she's talking about, we can invite her in, this is okay". p. 199.
Finding7	Community participation is important.
Illustration	"you just can't walk in knowing everything, you've got to work with the community and get their ideas and work with them on achieving it" p. 199.
Finding8	AHWs ensure cultural appropriateness for the Aboriginal community.
Illustration	"my clients trust that I will bring people to the group that they are going to like and that they are going to respect them and treat them nicely and all of that, whereas if I get a worker that I know is just not going to, I just wouldn't even invite them" p. 200.
Finding9	Relationship building happens informally.
Illustration	"it's a very open forum so that is a very natural and non-intrusive way to meet people". p. 200.
Finding10	Discussion occurs between Aboriginal and non Aboriginal staff.
Illustration	"it's natural for Aboriginal and non Aboriginal workers to come together and discuss things'. 200.
Finding11	Building relationships is key to working with the Aboriginal community.
Illustration	"creating those relationships, attending the lunch program, having lunch with community, just chatting and then being involved. That kind of shows the order of what is most important to Aboriginal community" p. 201.
Finding12	Relationships and trust take time to build.
Illustration	"that in order to build effective relationships with Aboriginal community and workers you really have to spend a lot of time building trust and being involved rather than just preaching to people about what they should do" p. 200.
Finding13	Reciprocity is important to relationship building.
Illustration	"Aboriginal people have had a lot taken from them over the years so it doesn't hurt to be able to offer something". p. 200.
Finding14	Relationship building is an enabler to working with Aboriginal people.
Illustration	"you cannot evaluate the significance of a relationship with Aboriginal community" p. 201.

Finding15	Relationship building in the workplace needs to occur on an informal basis.
Illustration	“if you have something that you need to give to somebody, instead of sending it through the mail, if it's not too much of an issue, just drop it off, like make yourself known but not in an assertive way” p. 201.
Finding16	Trust is transferrable.
Illustration	“if you build a relationship with those key people and they get to know you then they talk about you to the community and they will say oh yes,[name], she's actually alright” p. 202.
Finding17	The time it takes to build relationships was seen as a barrier.
Illustration	“Those with minimal experience had some awareness of the time taken to build relationships and this was a barrier when people were unable to think about their work long-term” p. 202.
Finding18	White people need to let go of white judgement for health relationships.
Illustration	“highlighted the need for White people to let go of negative beliefs and judgements if they are to have good relationships with Aboriginal people” p. 202.
Finding19	White workers relinquishing control is an important strategy for working with Aboriginal people.
Illustration	“these strategies avoid practicing in a way that reinforces colonisation. For example, instead of telling people what to eat, providing choices around what they are actually eating, or working with a community in terms of what they value and what they want rather than pushing your ideals or the ideals of a program onto the community” p. 203.
Finding20	Strategies for White workers include acknowledging your knowledge gaps and expectations.
Illustration	“acknowledging things about yourself such as admitting what you don't know, acknowledging that you need training and not being scared, not expecting immediate change and understanding the limitations of your work” p. 203.
Finding21	Strategies for white workers include acknowledging your White privilege.
Illustration	“Acknowledging that White people do not have all the answers and not assuming that their ideas are the best way to solve 'what we see as Aboriginal problems' were also reported as important strategies”

	p. 203.
Finding22	AHWs felt it important that White workers had awareness and understanding of Aboriginal history and culture, and their own 'whiteness'.
Illustration	“I think they just need to have an understanding of where we're from, or where we've come from and you know it is not just about an Aboriginal person anyway it is about understanding what their lifestyle's like, what their history is” p. 203.
Finding23	AHWs believe that for White people to be successful in their work with the Aboriginal community they need cultural awareness.
Illustration	“Aboriginal workers felt that if White health professionals had this awareness, then they would have a better approach and probably be more successful in their work with Aboriginal people” p. 203.
Finding24	White workers need to learn about Aboriginal culture using their own initiative.
Illustration	“take a bit of initiative to learn about it for yourself so that you're armed with that knowledge so that when people are telling you things you are hearing it within the context that it's being said” p. 204.
Finding25	Respectful communication is important for working with AHWs.
Illustration	“...when someone walks in the door, you smile and say good morning and make them feel welcome because that's what we're here for and if you can't do that well you shouldn't be working here” p. 204.
Finding26	Yarning is a way of making assessments more culturally responsive.
Illustration	“an Aboriginal person would rather sit under a tree and have a good yarn with you on the ground” p. 204.
Finding27	The Aboriginal community like to hear health information from people within their community.
Illustration	“Particularly when it is non Aboriginal people informing Aboriginal people about things, they need to know and why. Why are you bringing this program to us” p. 204.
Finding28	Commitment as a quality to work with Aboriginal community.
Illustration	“Aboriginal workers highlighted commitment as an important quality for White health professionals. This included wanting to work with Aboriginal people and persisting with clients who may be difficult to contact” p. 205.

Finding29	AHWs see value in white workers up skilling in cultural awareness training.
Illustration	“our workers who've never had experience or an opportunity to meet with Nungas we have to have something in there to support them in doing what they want to do” p205.
Finding30	AHWs report the need for non Aboriginal managers to have cultural respect training.
Illustration	“I've had a lot of managers say to me 'I've never met an Aboriginal person; I've never had the opportunity'. Now they are managing three Aboriginal staff. It's culture shock for both sides” p. 205.
Finding31	Aligning health agenda's with communities needs.
Illustration	“framing your agenda with whoever you want to work with, the workers, the community or whatever and getting them to see how your agenda could benefit them” p.206.
Finding32	Honesty and persistence described by both AHWs and White professionals.
Illustration	“Honesty and persistence where also considered elements of ideal practice by ewba staff and experienced White workers” p. 207.
Finding33	Reciprocity seen as important to AHWs.
Illustration	“and you don't ever hear anything back, do you know what I mean” Like you think I did my part there but you don't even get anything back” p. 208.
Finding34	Two way learning is an essential element to partnership.
Illustration	“...there's learning on both sides so they give you something and then you give them something” p. 208.
Finding35	Organisational culture promotes partnership.
Illustration	“[In community A there is] not that stigma about working alongside White people, and it is encouraged and, you know, there is integration” p. 218.
Finding36	Not providing staff with cultural awareness training was seen as a barrier to building good relationships with the Aboriginal community and workers.
Illustration	“And it's with such judgement it's frightening and that's one of the reasons why I will do everything I can to make sure that cultural awareness training, including an understanding of White privilege

	and dominant culture, is undertaken by every staff member on the health site" p. 219.
Finding37	Aboriginal specific positions enable non Aboriginal health professionals to develop skills in primary health care.
Illustration	"Aboriginal specific positions were also thought to enable the practice of White health professionals by providing a key contact person within an Aboriginal health team whose business is primary health care" p. 220.
Finding38	Difficult to perform the AHWs role.
Illustration	"it is actually really hard work as an Aboriginal worker to stay in that environment so we have to create a system in which we support workers to make sense of what's happening to them" p. 220.
Finding39	Ensuring AHWs are supported with enhancing the organisations ability to work with the Aboriginal community.
Illustration	"organisations could enhance their ability to work well with the Aboriginal community by first ensuring that their Aboriginal staff were happy and in a position to support each other" p. 220.
Finding40	Operating in 'silo's' can inhibit relationships between Aboriginal and non Aboriginal staff.
Illustration	"Aboriginal workers reported that mainstream organisations encourage people to work in defined work roles, which can lead to a tendency to operate in 'silos' which can inhibit relationship building and working partnership" p. 221.
Finding41	High workloads can impact on effective relationships.
Illustration	"leading to Aboriginal Health Workers becoming inundated with work. This may constrain effective relationships and action between Aboriginal and White workers" p. 220.
Finding42	Policies in mainstream do not adequately address the needs of Aboriginal people in the organisation.
Illustration	"we [Aboriginal workers] have got no rights per se in the HR [human resources] manual around leaving or working with community at sorry times' and 'policy says you can only take bereavement leave or compassionate leave if it is direct kin line" p. 221.
Finding43	Staff turnover a barrier to providing care to the Aboriginal community.
Illustration	"Aboriginal Communities have had different non-indigenous people coming in over the years and not trusting what they are actually

	about and having not time to build that trust". p. 222
Finding44	Perceived racism in organisations will deter access.
Illustration	"..there are still services that we don't use and ones that we will send people to and ones that we won't because of our own experiences there or we've heard things about racism and things like that, you know" p. 225.
Finding45	Structured nature of mainstream services are a barrier.
Illustration	"strict appointment time [where] if you don't turn up right on time, if you're five or ten minutes late well you have to reschedule" p. 225.
Finding46	Inflexible organisation structure poses problems for White professionals working with Aboriginal workers and people.
Illustration	"Our system isn't almost set up to be able to have that flexibility with Aboriginal health in general...we're trying to get them to fit into our world, we're not adjusting to fit into their world." p. 225.
Finding47	White workers need a broader view of their professional role, to enable practice with Aboriginal communities.
Illustration	"'supporting the community with ideas that they have and to encourage them with that and connect them with other people who might be able to assist and facilitate that process and offer some ways forward." p. 236.
Finding48	Reconstructuring the professional culture of the professional group the health professional belongs to.
Illustration	"...it is kind of like, okay, everything that you learnt as a dietician around programs and like you know getting stuff done and being assertive and you know speaking up and stuff, stop and actually like take a step back and just get to know who you are working with and then revisit some of that stuff" p. 238.
Finding49	Personal experience enabled health professionals to work with Aboriginal people.
Illustration	"...I believe that being Brown has actually been an advantage for me working with Aboriginal community because i'm not of a dominant culture" p. 244.
Finding50	Negative personal experiences impact the White health professionals ability to work with Aboriginal staff.
Illustration	"Even all the thinking that I've done, I can still flip into feeling frightened and then the kind of shame that went along with that, how

	easy it is to feel unsafe in relationships and how vulnerable we are as people" p. 245.
Finding51	An awareness of knowing there is more to learn facilitates partnership.
Illustration	"it's a Johari's Window, you know that thing about you know what you know and then there is the part where you can't know what you don't know" p. 246.
Finding52	Acknowledging limitations of knowledge is an effective strategy.
Illustration	"Aboriginal people appreciate that, they don't like to see someone sort of bluffing their way through it" p. 247.
Finding53	An awareness that racism exists is an enabler to good relationships.
Illustration	"Aboriginal people.....don't necessarily feel that they're going to get equal treatment, fair treatment, social justice wherever they move" p. 248.
Finding54	Working partnerships enabled White workers to develop an awareness of White privilege.
Illustration	"I couldn't have moved in that direction and understood more about White privilege and culture without that partnership" p. 249.
Finding55	White workers need to have an awareness of their position of power.
Illustration	"...we need to have an understanding of their culture, an understanding of White privilege, we need to understand that we carry that to the table when we're meeting with our Aboriginal colleagues or the community generally and we need to understand that they know that" p. 250.
Finding56	Health professionals need to understand colonisation and continuing impacts.
Illustration	"...that the Aboriginal community are living with the impacts of that every day still today and that when we talk about things like Stolen Generation that's not people who are dead and gone many years ago those people are people I work with today" p. 254.

Jackson D, Brady W, Stein I. Towards (re)conciliation: (re)constructing relationships between indigenous health workers and nurses. Journal of Advanced Nursing. 1999 Jan;29(1):97-103.

Finding1	Nurses lack knowledge and understanding about the roles and function of AHWs.
Illustration	"If you ask a white nurse what an Aboriginal health worker is, they'll have a totally different answer to what a health worker will." p. 100.
Finding2	AHWs did not understand the role of the nurse.
Illustration	"I'd like to see all our health workers trained in basic hands-on skills for their communities and get rid of the white nurse... because that's all they do, just the basic hands-on things". p. 100.
Finding3	Cultural needs of community takes primacy for AHW.
Illustration	"Aboriginal health workers are answerable to the local people first, then family and also a white Western health system". p. 100.
Finding4	Nurses do not understand AHWs are accountable to community first.
Illustration	"I think that a lot of nurses aren't really sure of the real role of an Aboriginal health worker, and the burden that they have to carry or the huge responsibilities that they have". p 100.
Finding5	Nurses tend to position themselves as 'in charge'.
Illustration	"The health worker might be seen by some nurses in a nurse aide type role...there to carry out instructions and do as she or he is told" p. 100.
Finding6	Difference in working conditions experienced by AHWs.
Illustration	"The nurses get given accommodation; they get given much higher pay, and better working conditions, whereas the health worker might be living in the back of a van". p 101.
Finding7	Lack of educational opportunities disempower AHWs.
Illustration	"They (nurses) think they're more superior because they're educated" p. 101.
Finding8	Lack of partnership.
Illustration	"but it will never be an equal partnership. If there is a white nurse there, they should be coming under the senior Aboriginal health workers. We should get rid of this hierarchy that keeps us down the

	bottom" p. 101.
Finding9	Nurses struggle delegating care to non nurses.
Illustration	"Also they raised the issue of the legality of it all, you know, what if something goes wrong" The nurse is the one responsible". p 102.
Finding10	Nurses having an educative role for non nurses.
Illustration	"That these nurses weren't qualified to educate and that some of the health workers may not have adequate background knowledge and that the nurses would have no way of knowing this" p 102.

Health Workforce Australia. Aboriginal and Torres Strait Islander Health Worker Interim Report. Second report in the Aboriginal and Torres Strait Islander Health Worker Project; 2011. p 346.

Finding1	Preventing and managing chronic disease is unavoidable when addressing the health needs of the Aboriginal community.
Illustration	"Diabetes, cardiac respiratory, mental health, smoking, substance abuse, otitis media, you name it. All the cancers you can think of. The related chronic diseases." p. 44.
Finding2	Mainstream health organisations do not meet the needs of the community.
Illustration	"When it comes to our emotional needs, our grief, our loss, our Stolen Generation needs " mainstream services don't address that well." p. 44.
Finding3	AHWs encounter the complex social/emotional needs of the community.
Illustration	"People dying and community social and emotional wellbeing is bad. Three kids tried to commit suicide last year and Aboriginal Health Workers have to assist in management." p. 44.
Finding4	AHWs address the Aboriginal social determinants of health.
Illustration	"Nutrition, because there is so much diabetes. This comes from poor finance for nutrition and poor housing, domestic violence, everything comes into it. If we see it when we go out we talk about it." p. 45.
Finding5	AHWs observe the social determinants of health impacting on the health status of their community.

Illustration	"We see a lot of kids that don't go to school because their parents don't send them to school, or they haven't got lunch, or they haven't got clothes. We have a lot of head lice, scabies and boils, school sores; it's a vicious cycle, the parents didn't go to school, the kids won't go to school" p. 45.
Finding6	The AHW workforce is an important strategy for Aboriginal communities to self determine their own health outcomes.
Illustration	"The government sees us [Aboriginal and Torres Strait Islander peoples] as stats but we are a dying race. They don't care what happens to us, we are just numbers. This is where the Health Worker comes in. We care. We are family. We want to make a difference to our lives" p. 46.
Finding7	Aboriginal community find health services difficult to access due to cultural barriers.
Illustration	"Mums and bubs never turn up to their [hospital] appointments because of the cultural barriers, they don't want to come in because of their dignity, the clinical smells, all of that is cultural stuff, they'd rather have their baby under a tree than see a hospital." p. 49.
Finding8	Non Indigenous staff attitudes act as a barrier to the Aboriginal community.
Illustration	"Sometimes staff attitudes can be an issue, clients don't feel comfortable with non-Indigenous staff." p. 49.
Finding9	Aboriginal community to not trust white dominant health services.
Illustration	"They have an Aboriginal Mental Health Worker and another Aboriginal Health Worker and a receptionist who is Aboriginal. But they have a big swag of nurses. Because it's mostly white dominant, they don't feel as comfortable and don't trust them as much" p. 49.
Finding10	Mainstream health organisations need to become culturally aware of the needs of the Aboriginal community.
Illustration	"If an Aboriginal and Torres Strait Islander person goes to a mainstream service and has a bad experience, then they won't go back to that service. Therefore they need to be culturally aware." p. 49.
Finding11	AHWs cultivate cultural safe health care provision.
Illustration	"We are the shield between the community and the other health staff, especially the nurses." p. 58
Finding12	AHW help overcome cultural barriers.

Illustration	"As soon as the doctor starts saying more than 10 letter words to the patient, they're lost, they can't understand. We have to sit there and advocate for the patient, encourage the patient to do the right thing as the doctor says." p. 58.
Finding13	The Aboriginal community is afraid of health institutions.
Illustration	"The Aboriginal and Torres Strait Islander people are frightened, they're frightened of getting sick, frightened of the hospitals, frightened of the medication. They will discharge themselves." p. 58.
Finding14	The cultural knowledge of AHWs needs valuing.
Illustration	"It's a big plus for Aboriginal Health Workers to have acquired their cultural knowledge and it is not valued enough. It should be respected as intellectual property." p. 58.
Finding15	AHWs bridge cultural divides.
Illustration	"They [Health Workers] are the face between the community and the health service" p. 59.
Finding16	AHWs increase the accessibility of health services.
Illustration	"It is critical to remember that this generation is the stolen generation. As a result they [Aboriginal and Torres Strait Islander clients] are very un-trusting of the government and particularly white government workers. The Health Workers are the key to the Aboriginal and Torres Strait Islander community. Health Workers have been able to open doors to the community never opened before." p 59.
Finding17	AHWs have a cultural scope of practice complementing a clinical scope.
Illustration	"It's just as important to acknowledge the cultural scope of practice as well as the clinical scope of practice. Even if a Health Worker doesn't have the clinical competence, some are excellent at mediating with the doctor and being a cultural advocate." p. 59.
Finding18	AHWs cultural knowledge needs valuing.
Illustration	"Cultural consultancy is a major role [of Health Workers], not valued by other health professionals" p. 59.
Finding19	AHWs employed from external communities need cultural mentoring from local community members.
Illustration	"We want to grow local jobs with local people. We aren't all one people. To really be effective as a primary health care giver, they need to be from that community. Community endorsing that person is

	vital for success." p. 60.
Finding20	AHWs need to be from the same cultural community as their clients.
Illustration	"Culture is very strong out here and it overtakes all other considerations. We cannot recruit Health Workers from other areas or send our Health Workers to other areas because the community culture requirements are so strong." p. 60.
Finding21	AHWs have a health prevention focus in their care delivery.
Illustration	"A lot of Aboriginal people think that diabetes is just something that is going to happen because you've seen your aunties and uncles with it. They don't realise it is something preventable. If a nurse just gives them a script it is not teaching them that it is actually preventable." p. 61.
Finding22	AHWs participate in health promotion activities with their communities.
Illustration	"I deliver a few programs to the community, like a healthy cooking program, good food, simple first aid with the kids in the school, nose blowing and cleaning hands and faces, home hygiene, diabetes, teeth program, blood pressure program." p. 61.
Finding23	AHWs approach health care with a health promotional view.
Illustration	"Once a doctor gives an Indigenous person a tablet or some insulin, they think they can keep drinking and smoking and eating because the medicine will fix it. That is why we have to change their mindset. So that they understand why they also have to change drinking and smoking and eating." p. 62.
Finding24	AHWs practice under a holistic view of health.
Illustration	"You find a lot of nurses have the acute approach to health care "it is different to Health Workers. We try to take a holistic approach, empower our clients, educate them so that they can address their own health issues. The program I run, Healthy for Life, is completely aligned with the Health Worker philosophy." p. 62.
Finding25	AHWs see the patient as a whole person and not a disease.
Illustration	"Health Workers work from a more holistic point of view. They see the person as a whole not just a disease process. For example, in comparison to Enrolled Nurses, Health Workers have a much greater and wider scope of practice." p. 62.
Finding26	The shortage in AHWs prevents AHWs performing their health promotional/ prevention roles.

Illustration	“The volume of work and number of patients stops us program people making a major difference. We need more Health Workers in the prevention stream of this service. For example in Child Health we have one Health Worker to 1,700 children: what can be done really” p. 67.
Finding27	AHWs need to be involved in program development from the very early stages.
Illustration	“We would like Health Workers to develop some of the community programs. At the moment they partner with programs that are already up and running. We would like Health Workers to drive these going forward.” p. 68.
Finding28	AHWs are prevented from translating their clinical knowledge into clinical practice.
Illustration	“I’m not able to do a lot of the things I am trained to do, for example venipuncture, because of the rules around what Health Workers can and can’t do.” p. 69.
Finding29	AHWs want access to professional development and training opportunities.
Illustration	“We want more support to update our skills with training, and to develop our skills in the workplace too. A lot of short courses are targeted toward nurses, or are just a waste of time.” p. 69.
Finding30	AHWs are disempowered in their work environments.
Illustration	“Recognition of the skills that we have; and allowing us to do what we are trained to do. Stop holding us back if [we are] trained and competent to do it.” p. 69.
Finding31	Self determinism by the Aboriginal community.
Illustration	“Aboriginal people looking after Aboriginal people “where the Health Worker is the first point of contact and hence Aboriginal people feel comfortable accessing the Health Service. The philosophy of Health Workers is: “We will help you help yourself”.” p. 74.
Finding32	AHWs enable health services to understand the community they are providing care for.
Illustration	“The best model is our model of Health Workers being the front line: they are the permanent staff and hence have the history and knowledge of the community needs as they are the community.” p. 75.
Finding33	Empowering Aboriginal communities to participate in health care

	builds trust with health institutions.
Illustration	"Where Aboriginal people are part of treating their own people " this builds trust and engagement." p. 75.
Finding34	Health services do not enable AHWs to have a role in the provision of comprehensive primary health care.
Illustration	"We identify and work within ourselves to address that, but mainstream health services don't support us to provide holistic care. They tell me I'm not a counsellor; I'm not there to do that. But it is an inevitable part of our role." p. 77
Finding35	AHWs are able to advocate for their client to be seen from a holistic view point within health care institutions.
Illustration	"Today there is not one specific health problem that stands out. In a holistic health manner one should and does not stand out. I get tired when people talk about specific health problems as all health problems and needs in our community is a concern." p. 78.
Finding36	AHWs are vital for health service delivery to Aboriginal communities.
Illustration	"Health Workers are fundamental to our service delivery model "A large portion of the Health Workers that work here are of the community " they have relationships and are able to communicate with the community members in a way that we cannot. They are vital in making sure that people come to the health service, stick to their care plans, etc. Also in feeding back to the service and telling us the community needs and how to respond to them. They are very much on the ground and operating and keeping the service alive." p 78.
Finding37	Community based approaches are successful in meeting local health needs.
Illustration	"Chronic disease is getting higher. Our younger ones have diabetes; it's getting more and more. We're addressing that. One program we have is about finding what we had to do for our mob, and we have someone from our community to help deliver that program. And now, most of the people on that program, their weight and sugar levels are coming down". p. 79.
Finding38	Local cultural competency is central to the AHW role.
Illustration	"You need local cultural competency not just generic cultural competency because you are Aboriginal and Torres Strait. Understanding of local community and valuing different types of knowledge is important" p. 98.
Finding39	AHWs need further training in counselling.

Illustration	“Some young mums are having relationship problems and want someone to talk to. So we have to do counselling that we haven’t really been trained in.” p.99.
Finding40	AHWs feel stressed providing social and emotional support due to lack of role support.
Illustration	“Trainees have been put under pressure to help outside their role like [providing] social services [such as] social and emotional support.” p. 99.
Finding41	Cert IV qualifications are necessary to enable AHWs to work in autonomous roles.
Illustration	“You can work at a Cert III, but those people need supervision “so why wouldn't you train a HW up to a Cert IV and have them able to work independently” p. 100.
Finding42	Unavailability of training programs a barrier for AHWs.
Illustration	I asked when I could start and they said in two years in 2012 “because all the positions were full.” p. 101.
Finding43	AHWs find it too hard to leave their families/communities to participate in training.
Illustration	“Can the training come to us so we stay in our community” We don’t want to leave our families, our communities, our jobs. We need more opportunities for scholarships, especially to do a specialty so we’re funded to do it. ABSTUDY isn’t enough when you’ve got a family” p. 101.
Finding44	Training methodologies for AHWs need to be inclusive of Aboriginal traditional learning styles.
Illustration	“Not so much book work. It needs to be hands-on at least every second block. Even visiting other services. Like going to _____ - like a sharing of knowledge. They took us to the library “ what do we need to go to the library for” p. 106.
Finding45	Lack of resources prevent training in local communities of AHWs.
Illustration	“No incentives or funding to go away from home to learn more. Family structures prohibit them from leaving, especially with kids and elders to care for. They could study online if they had more computer training and we could teach more here if we were funded to do it” p. 107.
Finding46	Lack of family support can be a barrier to training.

Illustration	“Family support or lack of family support is the number one barrier or enabler to education” p. 108.
Finding47	Numeracy and literacy is a barrier to AHW qualifications.
Illustration	“The single biggest barrier here to education is that of numeracy and literacy levels. Most of our Health Workers have not graduated from high school and both their verbal and written English levels are very low.” p. 108.
Finding48	Lack of career progression opportunities.
Illustration	“There needs to be a better career structure with future possibility of career progression” p. 109.
Finding49	Perceived lack of career progression prevents people accessing training opportunities.
Illustration	“The 'why bother syndrome' if they are at the top of the level anyway and cannot progress further or get better pay.” p. 109.
Finding50	The challenge of backfilling AHW positions prevents access to training.
Illustration	“One of the problems is that for us to go to study we need other Health Workers to be able to work in our place so we need more Health Workers in our service.” p. 109.
Finding51	Lack of career structure impacts on AHWs retention rates.
Illustration	“Today the career structure for HW's is very limited as soon as you become a Senior HW it stops. The career path is very limiting and hence people leave.” p. 110.
Finding52	AHWs become dissatisfied in their roles due to lack of career structure.
Illustration	“A structure where you work to a certain point in your role. A career path. Many of us go stale as there is no career path.” p. 111.
Finding53	The AHW role provides opportunities for articulation into other workforces.
Illustration	“I'm going to do nursing. We are pretty much doing the nurse’s job we just can't give out meds and immunisations. Next year I am going to do my nursing. As a Health Worker, you can only do a little scope of practice. Nursing you can excel. Nurses can get a job all over the world. Going to do it at university.” p. 111.
Finding54	Lack of recognition of prior learning and skills is a barrier preventing

	AHWs moving into other workforces.
Illustration	"There needs to be recognition of prior learning of Health Workers so that they can map across into other university qualifications. The Health Worker shouldn't have to negotiate individually and advocate for themselves. The process should be put in place for them to move across into universities and articulate into other professions." p. 113.
Finding55	Two way learning for both the AHW and non Aboriginal health care provider.
Illustration	"We learn a lot from the doctors and they learn a lot from us. We help the new registrars to learn how to deal with the Aboriginal community." p. 115.
Finding56	The clinical demands prevent the passing on of clinical knowledge and mentoring to AHWs.
Illustration	"[there is] Virtually none [training] because they are so remote and rely on the nurses and doctors to train them and they are just so busy coping with life in the community they cannot train them. People are walking through the clinic doors in such sheer volumes that accessing and doing training and mentoring with the other clinic staff just isn't feasible". p. 117.
Finding57	Health professionals can provide technical skills mentoring to AHWs.
Illustration	"Last year I had trouble doing my Certificate IV, until a couple of nurses showed me how to do it. When they came in and showed me how to do it, it just clicked. I can't read and write properly, but once they showed me, it just clicked " p. 118.
Finding58	AHWs need access to cultural supervision.
Illustration	"Cultural supervision will play an important role in the maintenance and retention of our workforce ... There needs to be strategies developed to formalise and embed this process into each organisation's strategic plans which will become part of standard practice " p. 119
Finding59	AHWs find networking with other AHWs beneficial.
Illustration	"We used to have that big forum once a year, one big debriefing. It's really helpful." p. 120.
Finding60	AHWs need to have formal opportunities to network with each other.
Illustration	"We should get together as all the Aboriginal Health Workers in the country. We should be able to go and talk together and bring the news back. We should have our own meetings but that doesn't

	happen." p. 120.
Finding61	AHWs get tired being available to the community all the time.
Illustration	"Sometimes we get midnight phone calls, or visited at home. I have dressings at home. Sometimes you just want to say no, but people can get very annoyed at that." p. 121.
Finding62	AHWs work a lot outside of working hours due to the cultural/community obligations.
Illustration	"We get phone calls at home and we are expected to do things for everyone outside of work hours." p. 121.
Finding63	AHWs experience burn out due to the close connections they have with their community.
Illustration	"We care about our people, and it hurts, we get upset when people pass away. One third of our clients are related to us in some way, so you get attached. There isn't debriefing or anything when things happen. We just go out for a smoke and talk. Burn-out rate is really high because it's so demanding." p. 121.
Finding64	AHWs need formal debriefing to manage compassion fatigue.
Illustration	"We are related to so many clients so we are always losing people " we need debriefing services to help us " at the moment we have to talk to each other." p. 121.
Finding65	AHWs fear 'pay back' from their communities when performing their job roles.
Illustration	"If we lose someone we have to worry about payback and this is so hard for us to cope with " will my job jeopardise my family and kids" p. 123.
Finding66	AHWs experience problems when supervised by members of other health disciplines.
Illustration	"There has been a tendency for AHWs to be placed in teams that are supervised by people who aren't ATSIHWs. So their experience and performance is ranked by a different system that is not applicable to HWs. The level of scrutiny I had was ridiculous "they have a different disciplinary background" p. 124.
Finding67	AHWs feel not trusted to perform their role by other health professionals.
Illustration	"They always want to know things like how long you are on the phone for, what was it about, what did you do at the home visit,

	what meetings are you going to. It's ridiculous. It is offensive. Up until a month ago I couldn't even look at my client's chart. We weren't allowed to access the files" p. 127.
Finding68	AHWs experience paternalistic attitudes from supervising professionals.
Illustration	"I don't have good supervision. Non-existent. What is happening is that sometimes team leaders take on a parental role with an AHW and over-supervise, micromanage, that is not respecting someone's professionalism and their individualism or independence. It says that we are untrustworthy." p. 128.
Finding69	Evaluation methods of AHW models of care need to take into consideration the nature of the AHW role.
Illustration	"Stats don't look good when I've been out driving all day in the hot sun and others[other health professionals] look as though they've been doing all the work." p. 131.
Finding70	AHWs experience mistrust in their roles.
Illustration	"Can they please listen to us and trust us. Trust your workers. I need to be treated as an adult, not a 16-year-old or an infant or a mental patient." p. 137.
Finding71	AHWs experience high scrutiny regarding the visibility of their roles.
Illustration	"They [other health professionals] keep an eye on us, they notice when you're not here, they see if you're there or not and then they go and tell others if you're not. They don't think we notice but we do. They don't realise that we are doing work even if we are not at our desk. If you're at your desk as a Health Worker you are disengaging yourself from the community." p. 137.
Finding72	AHWs feel undervalued in the workplace.
Illustration	"The nurses don't respect us or value us. They just call us when they need us to do something like round up the patients or something. We don't really get recognised. The nurses just think we drive around and do nothing all day. They've just learnt to deal with the fact that we're there." p. 138.
Finding73	AHWs experience other health professionals not understanding the scope of their roles.
Illustration	"The main problem here is the nurses don't understand our role or how we know the community. They think they know better. They don't see us as professionals but more as we are part of the community we can never be professionals. They use us to run

	around and do little jobs. They don't understand our ability and potential." p. 139.
Finding74	Health professionals working in organisations employing AHWs need education on the role of AHWs.
Illustration	"What we need to do is educate new professionals about what Health Workers do and what they are capable of. With the AMS, if you employ a doctor you should have Health Worker awareness training as part of the orientation." p. 139.
Finding75	AHW experience work place inequity.
Illustration	"Nurses and Health Workers often do the same, but nurses get paid double." p. 140.
Finding76	Professional recognition for AHW.
Illustration	"I would like to be seen equal and with expertise in my own area. All Indigenous employees to be recognised as equals in all areas." p. 140.
Finding77	Health professionals working alongside AHWs need to be on permanent contracts.
Illustration	"I want just the same whitefella to stay permanent. We don't like seeing all these different nurses coming through all the time. Some just stay in the clinic then they go home. They don't introduce themselves, they only know community by the ones they see in clinic." p.141.
Finding78	AHWs experience racism in the workplace.
Illustration	"Sometimes it is blatant racism " like "you can't be doing this because you're black"." p. 142.
Finding79	AHW experience racism in their workplace as an obstacle to having a 'voice'.
Illustration	"Racism is still an obstacle in the workplace especially with the nurses ... There is no support for us up here. We need a strong voice " someone who can be diplomatic." p. 143.
Finding80	Non Aboriginal health professionals need cultural respect training.
Illustration	"Non-Aboriginal or Torres Strait Islander Health Workers need cultural awareness training and understanding " this is critical." p. 143.
Finding81	Ongoing cultural awareness training is essential for non Aboriginal

	managers of Aboriginal staff.
Illustration	"Cultural awareness amongst non-Aboriginal managers. They need to understand our family and kinship system which is really strong. Things not seen as a 'big deal' by them are to an Aboriginal person. They should all do cultural awareness training regularly." p. 143.
Finding82	AHWs need to be included in strong management processes and structures.
Illustration	"We need to bring them back. It used to give us an update, a chance to air our grievances, have our voice heard and hear about the needs of our community." p. 147.
Finding83	AHWs prefer to be managed by Aboriginal staff.
Illustration	"We're happy in our jobs now, people want to come to work here. Having a non-Indigenous manager didn't work, we need someone who will fight for us. But now we have an Aboriginal manager it's now good." p. 147.
Finding84	AHWs are not renumerated for the actual hours worked.
Illustration	"Burn-out rate is really high because it's so demanding. We get paid 8-4 but we go home really late." p. 153.
Finding85	Supportive management practices contribute to AHW satisfaction at work.
Illustration	"Nice environment, safe practices, culturally appropriate workplace and recognition and respect for traditional cultural activities within community that can take us away from work at times." p. 156.
Finding86	Their needs to be nationally consistent pay scales for AHWs.
Illustration	"We need salary scales to be the same in all sectors, so that if you work for one group you get the same as other Health Workers with the same education and experience." p. 161.

Hecker R. Health Worker Tjuta kunpuringanyi. Health Workers' becoming stronger. A study of the factors affecting the empowerment of the Aboriginal health workers on the Pitjantjara Lands. Adelaide: Flinders University; 1994.

Finding1	Qualifications assist with AHWs being observed as equal 'expert' members of the health care team.
Illustration	"anangu [our people] haven't had the opportunities to gain the

	knowledge they need to compete - they need tertiary education to talk on an equal basis. They need confidence in the area of expertise". p. 132.
Finding2	Low literacy and numeracy influences employment of health workers.
Illustration	"The mayatja [manager] is employing 'half-castes' because they speak better English" p. 142.
Finding3	Lack of confidence in the English language by AHWs limits the AHWs sense of authority comparable to non Aboriginal health staff.
Illustration	"They're very shy on the phone to hospital staff - we can bung on an authorative voice when speaking to hospitals to get things done or find out information. This is very hard for the HW's to do". p. 144.
Finding4	Fragmented training blocks impacts on consolidation and implementation of knowledge for the AHW
Illustration	"You get a little bit of training and then you have to wait a long time before you get more training - it should be constant. The training we get now is not enough" p. 150.
Finding5	Limited access to an AHW educator creates frustration for the AHW trainee and delays completion of qualification.
Illustration	"I have not had a training for 1 year - the educator is always catching up the new HW's which means the HW's who have been working for a long time can't get past Block 2." p. 150.
Finding6	AHWs find that the non Aboriginal health staff do not provide them with enough training with the clinics.
Illustration	"Some white staff won't train the HW's in the clinic because they think it is not their job" p. 151.
Finding7	AHWs have limited opportunities created for them to implement certain skills that they have had the training for.
Illustration	"We've been taught how to do stitching and putting in drips but most sisters and doctors won't let us do it. We get more of a chance when they go on holidays". p. 152.
Finding8	AHWs express a desire to work in partnership with the nurses.
Illustration	"The sisters and HW's should work tjungu [together]". p. 152.
Finding9	Non Aboriginal staff should be taking an active role in encouraging AHWs to learn new skills.

Illustration	"It is different for white fellows to learn because dark people are more frightened- they need more encouragement from white staff" p. 153.
Finding10	Community members believe that the non Aboriginal health staff should be delivering more training to the AHW.
Illustration	" The sisters should be doing more training" p. 154.
Finding11	Community members believe that more qualifications for the AHW will lead to increased workplace equity for the AHWs.
Illustration	"They should have more training so that in the future they can be equal to the sister. They need a strong training" p. 154.
Finding12	Non Aboriginal health staff view AHW training as lacking rigour and impacting negatively on their working relationship with AHW.
Illustration	"The HW training is not consistent and not committed. If we saw that the HW's had a more rigorous course our relationship with HW's would be different" p. 155.
Finding13	Non Aboriginal health workers believe that poor quality training disempowers the AHW in the health system.
Illustration	"There's been 5 new HW's since I've been here (two years) and there's been no training for them only the bits and pieces we give them - the new ones don't get a basic training. I think they'd feel a lot more empowered if they had a good training" p. 156.
Finding14	There is no support or emphasis on the teaching role that non Aboriginal staff have when working with an AHW.
Illustration	"our teaching role is not emphasised by NHC. There is no discussion about teaching duties, it does not get a mention at the clinical meetings" p. 156.
Finding15	Record of AHWs level of competency and health knowledge is not communicated to the non Aboriginal staff.
Illustration	"It's hard for me to know what the right thing to do is - whether to teach HW's or not. It's hard to know if they've been taught it all before and I'm just repeating what they already know and being patronizing" p. 157.
Finding16	Non Aboriginal staff need access to information on indigenous learning pedagogy's to facilitate effective learning in the workplace.
Illustration	"If white fellows stand over, the HW's will stand back. We must give assurances as we go along. Anangu have subtle teaching ways. Sisters should actively show what they're doing. HW's must not be

	put on the spot before they are ready - they must not be shamed.” p. 158.
Finding17	Poor liaison between the AHW educator and the non Aboriginal health care providers means that there is no connection between what the AHWs learn in the formal teaching blocks and their work in the clinics.
Illustration	“after a teaching block last year we were not told what the HW's learnt and so could not consolidate the theory they were given with the practise in the clinic” p. 158.
Finding18	The community recognises that the AHWs do not have a voice in the health clinic, and the health clinic is not accountable to the community it serves.
Illustration	“There is no connection between the council and the clinic. We want the clinic to report at every council meeting and community meeting. The HW's should speak” p. 170.
Finding19	AHWs feel excluded from clinical goal and strategy planning meetings because of the different medical language that is used at these meetings.
Illustration	“They don’t include the HW's. They talk amongst themselves and use big words” p. 172.
Finding20	Some non Aboriginal health staff struggle with AHW's attending clinical meetings.
Illustration	“Clinical meetings are where protocols are find tuned and developed - it's important not to water down the debate so the HWs can understand it - this would nullify the effectiveness of the meetings” p. 172.
Finding21	HW's must be enabled to participate in decision making about how the health services are delivered at a much greater level.
Illustration	“Clearly if NHC's aim is to be delivering primary health care services which adhere to PHC philosophy then the HWs must be enabled to participate in decision making in a much more meaningful manner” p. 174.
Finding22	AHWs feel they have no voice in the health system.
Illustration	“Sisters just don't listen to my ideas” p. 176.
Finding23	HW's and community must be encouraged to take a more participative role with the health service.

Illustration	“For HW's to become empowered NHC needs to adapt its structures to foster much more greater HW participation in decision making both at the local and the regional level” p. 178.
Finding24	The community want HW's that come from the specific Aboriginal community they are providing health services to.
Illustration	“They are not Anangu, we want Anangu to work in the clinic for our community” p. 182.
Finding25	Managers recruit health workers that speak good English at the cost of employing health workers from the local community.
Illustration	“Anangu want Anangu HW's but I got this new one because she can speak English. Outside people work harder” p. 182.
Finding26	Community members do not have confidence in the training that AHWs receive, and therefore bypass the AHW.
Illustration	“If HW's get proper training then we would go to them” p. 186.
Finding27	The 'white' dominance in the workplace, impacts negatively on AHWs.
Illustration	“...once last year I was the only white staff in the clinic and the support I got from the HW's was great and there was a real team spirit from them which I never experience when we (whites)are all there. The clinics are too heavily staffed by white people which really affects the HW's” p. 187.
Finding28	In the interests of efficiency HW's are excluded because to involve HWs care takes much longer.
Illustration	“I think that we are all so efficient that we'll do the work just to get it done quickly without involving the HWs” p. 188.
Finding29	AHWs experience a lack of consistency and support at a management level.
Illustration	“He is not fair on the HWs. Says one thing and does another. He does not listen. He does not support the HWs” p. 189.
Finding30	There is a lack of equity regarding the benefits non Aboriginal staff receive, compared to the benefits AHWs receive whilst working for the health service.
Illustration	“Communities should look after HWs. HWs should get a house before others in the community. They look after sick people” p. 190.
Finding31	A young female AHW, lacks the position in the community to effect

	any behaviour change on health issues.
Illustration	“How can younger women tell people to shower their kids every day when it's shame job - they're not allowed to embarrass people” p. 191.
Finding32	Fear of payback from the community may limit a AHWs ability to be involved in treatment of a community member.
Illustration	“Pay back is still very strong. HWs don't want to give certain medicines because of payback situations”. p. 192.
Finding33	The AHW is placed in a situation of balancing a western medicine approach to treatment with a traditional approach to treatment.
Illustration	“the HW's accept our explanations of illness causation but speak of other things which cause illness too” p. 193.
Finding34	Non Aboriginal staff struggle with the haphazard and inconsistent working hours of AHWs.
Illustration	“I feel like I'm supported when the HW's are working with me - I feel like I'm deserted when they don't” p. 194.
Finding35	The ambiguity of the AHW role causes difficulties for non Aboriginal health care providers.
Illustration	“there is no structure for working out duties, who does what. In a normal ward in a big city hospital you know what you're supposed to do but here you don't know what you're supposed to do” p. 195.
Finding36	Lack of a formal orientation program for new AHWs poses difficulties for the non Aboriginal staff.
Illustration	“There should be an introductory module for all new HW's so that they just don't start without anything. This should be compulsory” p. 196.
Finding37	Non Aboriginal staff see all staff members as equals.
Illustration	“It seems like there are different rules for whites and for Anangu. There is no accountability and responsibility. I don't want to be a police women. I see us all as equals” p. 206.
Finding38	Some non Aboriginal staff can see the system and the organisation of work inherently devalues the AHW which impacts on work attendance.
Illustration	“The HWs don’t come to work because they don't have a realistic job - they have nothing to do or are implicitly put down” p. 210.

Finding39	Over dominance of white health professionals in the work environment impacts on AHWs feeling of pride in their abilities.
Illustration	“The feeling I get when we go to these meetings is that the HWs seem to enjoy themselves and they get a sense of pride by running the clinic” p. 210.
Finding40	Non Aboriginal health professionals see AHWs as a way of connecting and engaging with the Aboriginal community.
Illustration	“It is vital to have the HW's there with you - they are our means of communication with the community” p. 217.
Finding41	Non Aboriginal staff believe they can not instigate any preventative health programs as AHWs are often absent from work.
Illustration	“The HW's aren't here in any regular way and it's impossible to keep preventative programs going - we need the HWs support” p. 217.
Finding42	AHWs and non Aboriginal health professionals need to work together on preventative health issues.
Illustration	“The preventative health aspect of PHC is critical to bringing about improvements in the health status of Anangu and health teams need to work together with the communities in order to enable Anangu to reach a point where healthy choices become the easy ones” p. 220.
Finding43	Greater community participation in NHC will improve accountability.
Illustration	“In order to facilitate greater accountability there needs to be greater community participation both regionally and locally” p. 226.
Finding44	Clearer HW roles will improve accountability.
Illustration	“NHC to promote the HWs role and elevate their standing throughout the AP lands by making a video on the role of HWs. NHC to make it clear what HWs are accountable for” p. 231.
Finding45	Greater AHW participation in decision making will improve accountability.
Illustration	“HWs to participate more in decisions making within local clinics and within their communities on health issues” p. 233.

Homer C, Foureur,M, Allende T, Pekin F, Caplice S, Catling-Paull C. 'It's more than just having a baby' women's experiences of a maternity service for Australian Aboriginal and Torres Strait Islander families. Midwifery. 2012;28:509 - 15.

Finding1	Having a service based in the community was desirable for the community.
Illustration	"Having a local service that was easily accessible and had easy parking was seen as highly desirable and important. Women valued that they did not have to wait to be seen or to pay for parking that was very expensive at the hospital" p. 512.
Finding2	Accessing the services with AHWs provided a more intimate experience for the clients.
Illustration	"It's the best of both worlds; intimacy, with the hospital backup if needed" p. 512.
Finding3	Clients valued the personal relationships with caregivers.
Illustration	"an actual person, not just a number at the hospital" p. 512.
Finding4	Clients benefited from caregivers who knew their story.
Illustration	"know your story and why you are one of those who asks questions all the time-so they know when you are really concerned and when you are just curious" p. 512.
Finding5	Clients benefit from a more holistic view of care delivery.
Illustration	"It's more that just having a baby - it's about establishing networks, play groups, all sorts of sessions for mums to get together and talk and learn" p. 513.
Finding6	Aboriginal clients looking forward to appointments.
Illustration	"I look forward to my visits because I was coming to visit friends" p. 512.
Finding7	Clients feel comfortable not having to explain complex social issues.
Illustration	"I had been to midwife appointments at the hospital and they kept asking me about why I was on my own - at Malabar they knew me and I did not have to explain" p. 512.
Finding8	Importance of continuity of caregiver.
Illustration	"a familiar face was so important - I didn't really think it was important until this happened. I felt really relieved" p. 512.

Finding9	The relationship between the AHW and the client is transferrable to the non Aboriginal health care provider.
Illustration	“my midwife had to hand me over because my labour was so long - but it was to someone else from Malabar so i transferred that trust from my midwife to the next person and it was OK” p. 512.
Finding10	AHWs help build the development of trust with care providers and the health care establishment.
Illustration	“The AHEO's were important for the development of trust and the availability of support and having an AHEO as part of the service was critical. It was really important to women to have someone from the community in the service” p. 513.
Finding11	Cultural appropriateness of service.
Illustration	“I felt so important here and I never felt rushed in any appointments; I never was made to feel like there was a line of people waiting outside and I had to hurry up” p. 513.

Hooper K, Thomas Y, Clarke M. Health professional partnerships and their impact on Aboriginal health: An occupational therapist's and Aboriginal health worker's perspective. Australian Journal of Rural Health. 2007;15(1):46-51.

Finding1	AHW is seen as important to care delivery process.
Illustration	“I am always interacting with the Aboriginal Health Worker, every week really. My initial consultation will always be with the Aboriginal health worker” p. 48.
Finding2	Open communication exists in professional partnerships.
Illustration	“We have the freedom to talk to each other openly. We can really nut a problem out together” p. 48.
Finding3	Increase understanding of the different professional roles of each partner.
Illustration	“For the two professions to work efficiently and effectively together it is essential that there is a clear understanding of differing professional roles” p. 49.
Finding4	AHW had a function to provide additional information about the client.

Illustration	“To make sure we get the best understanding of the client. The more people that are involved and gathering information from the client, the better overall picture of the client” p. 50.
Finding5	Health professionals desire AHWs to have specialised training.
Illustration	“The perfect scenario would be having an Aboriginal health worker specifically trained and working in a rehabilitation role” p. 49.
Finding6	Professional collaboration improves services for the client.
Illustration	“It is certainly better for the client if we work together. I would be more likely to communicate regularly if it was going to help the client' p. 49.
Finding7	Collaboration provides a holistic service for client.
Illustration	“It is beneficial to the client, to be client centred and consider what is best for the client. I consider the therapy side and information from the Aboriginal health worker, collectively we put it together, drawing a better picture of the client” p. 49.
Finding8	Collaboration provides a holistic service for clients.
Illustration	“It is beneficial to the client, to be client centred and consider what is best for the client. I consider the therapy side and information from the Aboriginal health worker, collectively we put it together, drawing a better picture of the client” p. 49.
Finding9	AHWs are important for work to occur with the Aboriginal community.
Illustration	“Without the Aboriginal Health Worker I cannot do a lot of my work. In the communities I go to, I have the luxury of teaming up with the Aboriginal Health Worker. I can say 'these are the clients' and they can give me the background, let me know what is happening and we then go and see the client. I rely almost 100% on the Aboriginal Health Worker, we work together for the client. It is really important for the initial consult” p. 49.
Finding10	AHWs assist health professionals in navigating Aboriginal culture.
Illustration	“I think they[occupational therapists] rely on us pretty heavily until they feel more comfortable with our people” p. 49.
Finding11	AHWs assist clients in having a voice.
Illustration	“The clients are also a lot more comfortable with us there. They [clients] ask us the questions; sort of speak through us” p. 49.
Finding12	Employing AHWs benefits both clients and health professionals.

Illustration	“So that is beneficial for the occupational therapist and the clients, they are getting to hear about what the occupational therapist is doing in a way they can understand” p. 49.
Finding13	AHWs bring cultural insights to the health professional.
Illustration	“I was working with an Indigenous client and he and I didn't work well together, I felt like I was not getting onto a level that was really important to him. So, the Aboriginal health worker and I had a discussion and she was able to explain to him what I wanted to say, but it was in a way that was really meaningful to him“ p. 50.
Finding14	AHWs assist health professionals to provide culturally appropriate interventions.
Illustration	I would talk to the Aboriginal health worker about the appropriateness of an assessment I wanted to conduct and ask them what things I need to think of culturally” p. 50.

Bakos K. Our Healing Ways Supervision A culturally Appropriate Model for Aboriginal Workers: Victorian Dual Diagnosis Initiative: Education and Training Unit; 2012.

Finding1	Informal processes are an important strategy for engaging with Aboriginal clients.
Illustration	“...they rather just have discussions, go for a walk and have a talk... For a good conversation I get out with a client and sit down and have a nice cup of coffee or tea” p. 18.
Finding2	Trust is important for building relationships.
Illustration	“...and you get their trust and that's the main thing you need their trust” p. 18.
Finding3	AHWs utilise holistic approaches to deliver care.
Illustration	“participants spoke of not only attending to the MH and AOD[Mental Health and Alcohol and Other Drugs] issues but to all issues needing attending to” p. 19.
Finding4	Navigating the 'two worlds'.
Illustration	“I live in the community and so I'm gonna have a bigger expectation of me with confidentiality and I explain, just because you see me at the health service or the football or basketball your information is gonna be safe” p. 19.

Finding5	Non judgement communicates respect and fosters trust.
Illustration	"If you are there to engage with that person and to help them, you got to gain their trust and part of that means to respect them, not for what they did but for who they are at that moment" p. 19.

McGrath PD, Patton MAS, Ogilvie KF, Rayner RD, McGrath ZM, Holewa HA. The case for Aboriginal health workers in palliative care. Australian Health Review. 2007;31(3):430-9.

Finding1	Aboriginal clients are afraid of hospitals.
Illustration	"...when they are in hospital they are actually frightened because balanda all over the places in the wards" p. 433. 'balanda' refers to white staff
Finding2	Western medicine does not care for Aboriginal people.
Illustration	"What I reckon is something the communities doctors don't care about Aboriginal people" p. 433.
Finding3	Western medicine is not inclusive of Aboriginal healing methodologies.
Illustration	"I mean the whole ownership thing of knowledge thing is that unless that person is recognised traditionally as belonging to the knowledge of healing" p. 433.
Finding4	Cultural knowledge leads to recognition for AHWs.
Illustration	"people would listen to us, because we had the knowledge and that knowledge belonged to us, so therefore we were the right people to tell it" p. 433.
Finding5	Aboriginal patients prefer Aboriginal staff due to language barriers with English.
Illustration	"Aboriginal people don't want balanda all the time looking after them because some old people they can just understand small little bit of English" p. 433.
Finding6	AHWs who can interpret Indigenous languages assist with communication.
Illustration	"And that's where [it] would make a difference having someone around, whether as an interpreter or..." p. 433.
Finding7	AHWs can interpret the non verbal communication.

Illustration	"I believe strongly that [Aboriginal people] working with Aboriginal people can sense something that non-Aboriginal people can't - through what they say or their body language or how they look" p. 433.
Finding8	AHWs can negotiate the traditional Indigenous and Western health systems.
Illustration	"One of the main roles as an Aboriginal health worker is to help be a mediator between the two systems, Western and tradition Aboriginal culture." p. 434.
Finding9	AHWs have cross cultural understanding.
Illustration	"Yeah and understand our way of living, our life and feelings you know, culture and everything" p. 434.
Finding10	Successful appointment of AHWs takes into consideration the complex kinship and cultural ties.
Illustration	"They want a family member working there like from that group, clan group or tribal group" p. 434.
Finding11	Employment of AHWs increases Indigenous community participation and control.
Illustration	"because part of community participation and control and empowerment is employing Aboriginal people" p. 434.
Finding12	Inappropriate lack of Aboriginal employees.
Illustration	"I know that's what the Aboriginal Liaison officers are meant to be for but there's not enough here" p. 434.
Finding13	AHWs don't feel valued in the health system.
Illustration	"There are traditions and everything and there is that perception that they really aren't that favoured in the health system" p. 434.
Finding14	Turnover problems with AHWs.
Illustration	"unfortunately the Aboriginal health workers that we've had on the wards have found different positions, have moved on to other positions" p. 435.
Finding15	Employing AHWs form the local community could prevent the turnover of AHWs.
Illustration	"we should be looking at employing Aboriginal people and local Aboriginal people to make a sustainable service rather than people

	that just keep coming and going all the time" p. 435.
Finding16	Feelings of isolation, and wanting to connect with other Aboriginal workers
Illustration	"...sometimes because where I am situated at the hospital I am on my own" p. 435.
Finding17	Ensure AHWs are in a work environment that understands traditional Indigenous cultural obligations.
Illustration	"She never stops me or says that I'm unable to go to funerals and that" p. 435.
Finding18	Culturally insensitive management practices lead to AHWs resigning.
Illustration	"So therefore they're pushed by their family and they end up pulling out of those jobs because it does not support that cultural side" p. 435.
Finding19	Unclear job descriptions for the AHW role causes confusion.
Illustration	"without having that definite job description, they're a little bit at lost ends, and they don't really know what they're really supposed to be doing" p. 436.
Finding20	Confusion over the AHW role being social or clinical.
Illustration	"it's working is very messy and are they clinical or are they social" p. 436.
Finding21	Hospital environments favour Aboriginal staff being in an ancillary role compared to a clinical role.
Illustration	"The health system is more focused on the liaison officer and the interpreters than they are on the health workers in the hospital environment" p. 436.
Finding22	AHWs have ownership over traditional knowledge systems.
Illustration	"Really, you need the right person who's the right kin, who has the right understanding, who has the ownership of that knowledge, to be the person there" p. 436.
Finding23	AHWs are fundamental to service delivery.
Illustration	"if we didn't have them I just don't know what we would do. They are just brilliant" p. 436.

Robinson G, Harris A. Aboriginal Mental Health Worker Program Final Evaluation Report. Casuarina, NT: School for Social and Policy Research, Institute of Advanced; 2005.

Finding1	AHWs assist non Aboriginal health care providers to understand the cultural elements relating to a clients illness.
Illustration	“it is reported that AMHW's have significantly contributed to other practitioners' ability to understand background issues and cultural themes relating to client's problems” p. 52.
Finding2	Conflict exists around the role of the AHW being either clinically focussed or being health promotional focussed.
Illustration	“An issue that continues to elicit a range of often quite contrary views is the extent to which the AMHW's should focus on clinical service provision or work primarily outside the clinical arena in health promotion or general counselling” p. 53.
Finding3	Non Aboriginal health care providers view AHWs as having strengths in wellbeing work.
Illustration	““the emotional and spiritual wellbeing element is where the AMHW's strengths are, and our strengths our not” p. 54.
Finding4	Irregular work attendance by AHWs impact on their sense of ownership in the work space.
Illustration	“She hasn't been around consistently, it's back to square one now and unfortunately the power has been taken out of her hands. She probably doesn't feel a sense of ownership of the depot program at all now because the RN has been running it” p. 54.
Finding5	AMHW's add value to the delivery of health care to Aboriginal communities.
Illustration	“They are invaluable in that they are a source of insight into the culture, can work out who's related to who, know how to find people and know what's happening with the family” p. 55.
Finding6	Non Aboriginal health care providers feel unable to support AHWs in health promotion and counselling.
Illustration	“One of the problems we find at the clinic is that we're so caught up in doing acute work that we don't get the time to do prevention work” p. 55.
Finding7	Colonial history impacts negatively on the relationships between Aboriginal and non Aboriginal staff.

Illustration	"There are so many obstacles for Yolngu in this community because of the inherited colonial history and because of the kind of baggage that comes into the interaction between Yolngu and balanda and there's so much room for interesting workshops to improve the relationship between the two" p. 56.
Finding8	Health professionals view AHWs that are able to understand both Aboriginal and non Aboriginal culture as being an advantage to their role.
Illustration	"Why Djanumbi's a great person for this job is that she can put a foot in both camps. Djanumbi is a person who presents herself incredible well outside her community with her ideas she's a really strong thinker, really assertive, good literacy skills" p. 56.
Finding9	AHWs often are forced to take on an ancillary role in health care setting.
Illustration	"Our AMHWs juggle millions of roles. Being cultural broker, the interpreter, the social worker and the go between is a huge responsibility but I think it puts them in a secondary role and I think that's always going to be problematic within the health centre." p. 56.
Finding10	Non Aboriginal health care providers struggle providing care that is not delivered in the clinical paradigm in which they have been trained.
Illustration	"There have been a few half arsed attempts to get some things going, regular excursions and hunting programs shifted away from the clinical paradigm, and I think we have to take some blame for that" p. 57.
Finding11	AHWs don't like working in isolation.
Illustration	"no Yolngu like to work in isolation. Her getting Guymum on board is probably a good reflection of that" p. 57.
Finding12	Non Aboriginal health care providers lack the skills and experience to support AHWs in implementing community development work.
Illustration	"but we are non Aboriginal health care providers, ... and non Aboriginal health care providers aren't very good at community development work. So we don't really know we don't have good ideas on how to do this stuff and we don't have the experience" p. 57.
Finding13	AHWs make it easier for the Aboriginal community to engage in services earlier.
Illustration	"we had one medical evacuation a month, one every two months, at

	least six a year. Now one or two a year if we are lucky. We haven't had any for about a year now....people are recognising that when they're mentally ill, or when their relatives are mentally ill they can actually come to the clinic and get something done for it to alleviate the symptoms" p. 66.
Finding14	AHWs express a desire to work in partnership with non Aboriginal health professionals.
Illustration	"If we don't work together, we're all stuck in the mud" p. 68.
Finding15	Increasing the AHWs clinical focus in their work would empower AHWs and assist the health service.
Illustration	"but i certainly think that would be more helpful, would empower them more and it would give them more autonomy, if that's the way they wanted to go....they may be able to take on more total patient care for those people who are just on a maintenance program, rather than having to bring them in for a zuclo injection and getting one of the nurses to help". p. 68.
Finding16	Non Aboriginal health care providers are aware of not putting unreasonable work loads on AHWs.
Illustration	"...we don't want to stress them out too much. That's the other thing to consider, putting unreasonable workloads on them" p. 69.
Finding17	Lack of clinical preceptoring and mentoring can undermine the AHW position.
Illustration	"The AMHW wanted to get training in mental health care now because she doesn't want to feel that she is useless in the clinic. She comes in, she doesn't know what to do. I gave her directions, she came to sit in with me a few times, but sometimes you get busy and...It was a little unclear what her role could be" p. 127.
Finding18	AHWs need provision of clinical training in order to support the clinical component of the AHW role.
Illustration	"having those clinical skills would be beneficial, because you need a certain degree of clinical experience to do the job. When you look at an Aboriginal person they have spiritual and emotional as well as physical problems and the whole approach is supposed to be holistic" p. 134.
Finding19	AHWs need training which helps them bridge the Indigenous/non-Indigenous approaches to health care delivery.
Illustration	"It's aimed predominantly at your traditional Aboriginal person, so your counselling is sitting down with them, doing things with the

	family. But we actually need mainstream counselling skills that are more aimed at cultural beliefs. We need some Western counselling skills to go with the cultural counselling skills we got" p. 133.

Simmonds D, O'Rourke P, West L, Davies M, Holland C, Tangey A, et al. You can tell us your things and we'll teach you ours." A 'Two Ways' Approach to Improving Antenatal Education for Ngaanyatjarra Women. Aboriginal & islander health worker journal. 2010;34(2):10 - 4.

Finding1	Forums for Aboriginal community and non Aboriginal staff to share knowledge.
Illustration	"You can tell us your things and we'll teach you ours" p. 12.
Finding2	Important to maintain traditional practices.
Illustration	"They can go hospital. Palya! (thats alright!) (but when they return with the baby) they gotta go straight to the older people". p 12.
Finding3	Responsibility of elders to teach younger women.
Illustration	"Older ladies should learn (teach) the younger ones" p. 12.
Finding4	Young women want to learn how to look after their babies from western and Aboriginal perspectives.
Illustration	"Young girls from "the community" want to learn how to look after baby good way .....two ways" p. 12.
Finding5	Health services to encourage community participation.
Illustration	"true community participation in the design, maintenance and evaluation of all aspects of a health service needs to be enabled by health service providers" p. 13.

Stamp G, Champion S, Anderson G, Warren B, Stuart-Butler D, Doolan J, et al. Aboriginal maternal and infant care workers: partners in caring for Aboriginal mothers and babies. Rural and remote health. 2008;8(3):883.

Finding1	AHWs perform clinical work alongside providing social and emotional support.

Illustration	“We get the girls to come up to the hospital if they want to have their antenatal screening.... and so we have to go out and arrange that.. and bring them into the midwives...the midwives are doing mainly the antenatal screening on the girl, but us AMIC workers, well me, I am trained in that area so I also do the checks along with them” p. 4.
Finding2	AHWs provide education to Aboriginal clients.
Illustration	“after that - postnatal support as well, you know, help them with breastfeeding, and teaching them how to breastfeed and referral” p. 5.
Finding3	AHWs assist in providing care to Aboriginal clients who do not speak English as a first language.
Illustration	“If its a more traditional women then we make sure we look at.. all the things that we can offer which language group they belong to....” p. 5.
Finding4	AHWs through advocacy, enable Aboriginal families to have a voice in health services.
Illustration	“..a lot of the girls that you come across are like that, they don’t want to talk to the nurses, and so they tell you, and they want you to go and talk to the nurses...” p. 5.
Finding5	AHWs benefit from knowing how to work within or interact with mainstream health services.
Illustration	“I think it's important to know how to deal with mainstream services. They don't know our way and sometimes they push things the other way- that they want them. But I think it's important to have strong Aboriginal women working in the program so that we can stop and say: No, hang on a minute, that's not the way to do it, that's not the way we do it, when it comes to our women, this is how it should be done” p. 5.
Finding6	AHWs and non Aboriginal health care providers have mutually dependent roles for partnership to be successful.
Illustration	“ I think non Aboriginal people and Aboriginal people working together is a good way. Non Aboriginal people can't offer the service without us, but we can't do it without them either” p. 5.
Finding7	AHWs rely on health professionals to teach clinical knowledge in order to do their role properly.
Illustration	“..the clinical knowledge that we learned from the midwives, you know, without that, we couldn't do our work properly” p. 5.

Finding8	Health professionals are reliant on AHWs to share their cultural expertise.
Illustration	“they couldn’t do it without us because they need our cultural knowledge. They need to know the way we deal with people. And I think the good this is this; they teach us the clinical way and we teach them the cultural way” p. 5.
Finding9	AHWs believe that their input in care provides clinical benefits.
Illustration	“Aboriginal health workers doing that work with our girls, it's got to improve for the women and for the babies” p. 6.
Finding10	Clients trust the non Aboriginal health professional if they see a good relationship between them and the AHW.
Illustration	“But after a while those girls start to feel comfortable with the midwives as well, because they can see us working together” p. 6.
Finding11	AHWs value working alongside non Aboriginal health care providers who value what they say.
Illustration	“they are willing to listen to what we say and they work along with all of us” p. 6.
Finding12	Successful partnerships between AHW and non Aboriginal health care providers has positive benefits for the Aboriginal community.
Illustration	“I think Aboriginal Health Workers should be working with midwives everywhere, and you can really see the difference it makes, you know, for women and babies” p. 6.
Finding13	Health professionals have a role in developing the clinical skills of AHWs
Illustration	“For the midwives, it's not just about looking after the women...but a big part of it was supporting those AMIC workers in their learning and all that is to do with that” p. 6.
Finding14	AHW are happy in the work environment if they have a non Aboriginal health care provider who wants the model of care to be a success and shares clinical knowledge.
Illustration	“dont want it to fail, make sure their clinical skills and competencies are up to date so they're a happy member of the team” p. 7.
Finding15	The clinical skills of AHWs were viewed positively.
Illustration	“is as good as a midwife no, really, she knows when the tests are due all that sort of thing. I can say to her 'Can you look after this girl'”

	and I know there is nothing she doesn't know" p. 7.
Finding16	The care is shared between health professional and AHW, relieving the load for the health professional.
Illustration	"she knows when to go and get some help so I could easily go on holidays and she will contact the doctor if she needs to and I know that girl will be well looked after" p. 7.
Finding17	Health professionals need to be available on a daily basis.
Illustration	"but in the beginning, even with the experienced ones...you really needed to look after them and make sure there was someone there each day" p. 7.
Finding18	It takes more time for a health professional to work inter-culturally.
Illustration	"We have got other work commitments as well and it's not like all we have to do" p. 7.
Finding19	AHWs cultural knowledge is valued by the health professional.
Illustration	"They know where and how to find people etc - where and when and how long they have been in town and you know, all that sort of stuff, its fantastic" p. 7.
Finding20	Ambiguity around the AMIC role causes anxiety for the health professional.
Illustration	"No - one ever produced a job description per se. They would go... to the regional meeting, and a lot of the time I would be asking what skills can we pass on to the AMIC worker and how far can you go" And the answer I guess was 'It depends on the skills of the person and their qualification" - and it does vary..." p. 7.
Finding21	Health professionals can feel intimidated by the role of the AHW when new models of care are implemented.
Illustration	"In the early days I think it was - the difficulty was - with the mid staff, there was lots of negative comments about a new model of care, they seemed threatened, didn't want it to work" p. 8.
Finding22	AHWs experience shame when their skills are not utilised in the work environment.
Illustration	"And there was a lot of difficulty with them standing around without things to do, and they felt shame, but that's changed now because the AMIC workers are becoming more confident" p. 8.
Finding23	Health professionals also learn, when working with AHWs.

Illustration	"it goes both ways, so at the end of the day we have to keep reminding ourselves that this is AMIC worker led...and I have learned to listen" p. 8.
Finding24	Employing AHWs increased use in services.
Illustration	"..Mainstream services were not working so we have made huge increase in the numbers coming for their antenatal visits, it's really improving" p. 8.
Finding25	Cultural benefits are observed for the women and extended Aboriginal community.
Illustration	"It's wonderful when the grandmothers are there and it's done traditional way, those ones do really well. It's so rich and fulfilling" p. 9.
Finding26	Health professionals request cultural learning from elders in the community.
Illustration	".. but we need to learn about these things to be of assistance and in our work. I'd like more input of the Elders, of the grandmothers, so we can have their knowledge" p. 9.
Finding27	Health professionals request more support around language and culture.
Illustration	"I think I need to learn more about their culture and to learn some of the common words which they use you know Aboriginal literature or languages" p. 9.

Taylor K, Thompson S, Smith J, Dimer L, Ali M, Wood M. Exploring the impact of an aboriginal health worker on hospitalised aboriginal experiences: Lessons from cardiology. Australian Health Review. 2009;33(4):549-57.

Finding1	Hospitals represent colonialism for the Aboriginal community.
Illustration	"Hospitals are colonialism... that's where the people go and we don't see them again...it's the place you go to die.." p. 551.
Finding2	AHWs ensure effective exchange of health information with the Aboriginal client's.
Illustration	"When they don't look or give you eye contact, it could be a sign of respect or something completely different, like they are shamed, so you need to know so you can communicate properly" p. 552.

Finding3	AHWs employ cultural processes to communicate with their clients.
Illustration	“You sort of yarn and educate all in the one” p. 552.
Finding4	AHWs help to demystify the hospital experience for clients.
Illustration	“One patient had said to me he thought he was going for five different operations because he was seeing five different doctors and no one had explained it to him” p. 552.
Finding5	AHWs enable Aboriginal patients to overcome communication difficulties with non Aboriginal staff.
Illustration	“...[the staff] shout at us like we're deaf. And all it is, is the we can't understand the English; the orientation of everything... And one day I said “ I'm not deaf and I do speak English” ... It makes you feel disgusting. Very patronising” p. 551.
Finding6	The presence of an AHW, enabled clients to interact more with non Aboriginal staff.
Illustration	“Several hospital staff commented that having the AHW on the ward visibly affected Aboriginal patients, who appeared calmer and less anxious and were more likely to engage with other staff” p. 552.
Finding7	AHWs help reduce the incidence of discharge without medical advice (DAMA).
Illustration	“...and the AHW told us 'you need to move these patients straight away otherwise someone will walk.' If she wasn't there we would have had a DAMA situation” p. 552.
Finding8	AHWs increased the time available for patient contact due to the extra resource allocation.
Illustration	“As the AHW visited the ward twice a day she had twice as many opportunities to provide heart health and CR education to Aboriginal patients” p.552.
Finding9	AHWs help improve Aboriginal identification.
Illustration	“Community knowledge meant the cardiology AHW was less reliant on hospital admission data, and able to identify some Aboriginal patients when looking at their surnames on the inpatient board” p. 553.
Finding10	AHWs share information with health professionals to increase their understanding of Aboriginal culture.

Illustration	"..there are little things in daily discussion I would tell the nurses. Like, out in the community, their medications get stolen and you need to factor that into their care plan...and it was shock, like "really, does that happen" p. 553.
Finding11	AHWs increase health professionals understanding of Aboriginal culture.
Illustration	"I got a better appreciation for Aboriginal people. I realised how important family is to them, and I'm a lot more empathetic about their community difficulties" p. 553.
Finding12	AHWs lack clinical opportunities to translate their clinical training into practice.
Illustration	"When I went for the interview they said that it was education and some clinical, but when I got there it was just education. I have not done any clinical...Even though you've had all this training....I mean, I can do injections but I'm not allowed to, and I'm thinking, "Bugger this" p. 553.
Finding13	The complex social issues in the Aboriginal community impacts the AHW practicing to their full scope of practice.
Illustration	"...because I was the only Aboriginal person pretty much on that ward the education side of things were put to the side a little bit because they came to me for all their social stuff" p. 554.
Finding14	Ensure adequate orientation for the AHW when commencing.
Illustration	"hospitals must allow adequate time for AHWs to become comfortable within the environment and to provide basic training in medical terminology and procedures" p. 554.
Finding15	Link AHWs to other Aboriginal staff in the organisation.
Illustration	"supporting the AHW to build collaborations with other Aboriginal health staff in the hospital is important in terms of providing workplace support and contributing to retention" p. 555.
Finding16	Have a clear definition of the AHWs role.
Illustration	"Having a clearer delineation of job role responsibilities is critical in 'mainstreaming' the AHW role in the hospital" p. 555.
Finding17	Ensure AHWs develop and maintain links with primary health care services.
Illustration	"sufficient time must be allocated for the AHW to develop and maintain service linkages with primary health care services including

	Aboriginal Medical Services” p. 555.

Wilkin A, Liamputtong, P. Indigenous Voice and Vision: The Experience of Indigenous Women Working in the Victorian Health Service through Photovoice. Journal of Australian Indigneous Issues. 2010;13(4):45 - 68.

Finding1	Display of the Aboriginal flag in the workplace communicates commitment to the reconciliation process.
Illustration	“The flag, so that was really important step, it's only something small but it's very symbolic of the hospitals commitment to reconciliation” p. 51.
Finding2	AHWs view Indigenous symbols displayed in the workplace as a sign that the hospital was supporting them in their role.
Illustration	“It's indigenous issues being visual around the hospital. The hospital taking us seriously and supporting us.” p. 51.
Finding3	AHW draw strength from culture.
Illustration	“That’s healing culture and strength. When I look at it, it gives me strength” p. 52.
Finding4	AHWs enjoy rewards from serving their own community.
Illustration	“it's lovely, it's very calm and peaceful, you get a lot of rewards out of helping other people” p. 55.
Finding5	AHW acknowledge the diversity across the Aboriginal community
Illustration	“I just wanted to reflect how diverse we are. How diverse all our members are. We're all Victorians but we are very different. Every community is different like they have different needs and like we have 11 services but they are all different...It's amazing” p. 53.
Finding6	AHWs see value in working from a primary health care perspective.
Illustration	“Until we start making Indigenous health actual primary health care, the first step about health, to being sustainable development, we'll always be dealing with these difficult social factors” p. 53.
Finding7	AHWs feel an acute sense of community obligation and responsibility.
Illustration	“Often, you will get people coming in that you know or that are relatives, or they're your cousin or your aunty and that can be pretty

	confronting. Even if they're not, it's a small community so you want to be able to do everything you can to help but sometimes it's like well you have to say no, and you have to be the bad guy which is really, you can imagine what kind of affect that would have in a small community ...” p 54.
Finding8	AHWs experience a holistic view of health.
Illustration	“Part of healing ourselves is healing our environment, especially for Aboriginal people if your environments in a sick state you sort of take it all in, the vibe. So if we can keep our environment friendly and beautiful then it helps your own health' p. 54.
Finding9	AHWs bring a spiritual view of health.
Illustration	“The three flames is spiritual to fire which is cleansing and then us as women holding hands that we are one, and while we are one and doing our ceremony Bunjil is always watching over us' p. 55.
Finding10	AHWs address the social determinants of health for their clients.
Illustration	“'cause sometimes people can't have a good meal if they don't have a home to live in with a fridge. So that's not a main priority...so you have to sort out what factors are affecting their health” p. 55.
Finding11	AHWs value autonomy in their roles.
Illustration	“The fact that you sort of the one that controls where the program goes...and they sort of look to you for advice” p. 55
Finding12	Important of networking with Aboriginal staff.
Illustration	“a forum where they can share information, network, and have guest speakers its really good. I went to my first one last year and it was probable the best thing I've been” p. 56.
Finding13	AHWs can bring about change in Aboriginal clients health behaviours and attitudes.
Illustration	“you can get them really interested in it and wanting to change and at the start you might deal with some confronting issues but then once they get over that little hurdle and they're ready to work on themselves” p. 56
Finding14	AHWs are able to bring about change to the health inequity facing Aboriginal Australians.
Illustration	“I'm actively contributing to the betterment of them, that is the health status of Indigenous Australians and through that I think it starts at maternal health care because you can't do everything so in my

	viewpoint you start at the very starting block and that's is when a child is born we give it the best possible health from day one" p. 56.
Finding15	AHWs are motivated by wanting to make a difference to their community members.
Illustration	"What motivates me is my love of the community and wanting to make a difference" p. 57.
Finding16	AHWs find not being paid outside of their contracted hours as a barrier to their roles.
Illustration	"And because that's the nature of our work and we work in a system that doesn't recognise or support that through pay. That's a difficulty and it's also difficult because you're at work for very long hours" p. 57.
Finding17	AHWs find the paperwork a barrier to their roles.
Illustration	"Policy and things are just a nightmare...but they're some of the things you have to get your head around" p. 57.
Finding18	Reading and writing policy documents can be a stressful barrier to job role.
Illustration	"That's what I find stressful. I do find stressful too much reading...you know when there's gotta be big documents and write this write that...nah" p. 57.
Finding19	AHWs find barriers to their role in the structures and management of their workplace.
Illustration	"It's just like concrete. You know, there's no flexibility at all....well you can't be. And then there's sort of head banging because they'd want things to be culturally appropriate so you'd sort of give advice on certain things but their attitudes. Like they always thought 'well we're of the highest intellect but you know nothing' and I found that tragic" p. 58.
Finding20	Poor management practices impact on the AHWs enjoyment at work.
Illustration	"they're dumped in an office and 'go and make friends with mainstream' and take a client here and here" p. 58.
Finding21	High staff turnover is challenging.
Illustration	"we've had a lot of staff turn-over, that's been a big challenge for me and Kelly to bring new workers on board. Just to get them up to date in what the programs about, how much funding they've got, their limits and boundaries...I think that's been our biggest

	challenge....staff turnover" p. 58.
Finding22	Positive training experiences and support helps retain AHWs in their roles.
Illustration	"I think that's helped staff turnover because people we're leaving because they weren't getting trained" p. 58.
Finding23	AHWs experience difficulties with not provided with adequate training for their role.
Illustration	"..like they have some experience because they are part of the community and they know it, and what their needs are but it's really hard when they don't have the health and ground training" p. 58.
Finding24	AHWs need to apply for funding to sustain their programs.
Illustration	"The same money in a bucket and we were all fighting for it...and we lost. It was a bit of a downer for us." p 58.
Finding25	Connectedness to community can be a barrier to the AHW role.
Illustration	"and then I had to deal with my own family members that were dying and normally if your working in social work and it's your family member they put somebody else on the case but I had to deal with all those cases" p. 59.
Finding26	AHWs experience frustration by not being able to take on a preventative approach to health care.
Illustration	"a lot of the stuff we see is really repetitive, as in drug issues, homelessness, all that sort of stuff. It can burn you out. And seeing the same problems is frustrating" p. 59.
Finding27	AHWs are still working when they have left work due to their connectedness with community.
Illustration	It's community and socialising and living it's not as if I can leave the hospital and switch off" p. 59.
Finding28	AHWs experience the health inequity between Aboriginal and non Aboriginal Australians.
Illustration	"Then there's 25 women on a ward that have all that. And our women, if there not there for abuse or rape, it's unplanned it's young, they're smoking a lot of cigarettes, the babies prem and underweight, she doesn't have housing let alone a stable income, and life is really difficult" p. 59.
Finding29	AHWs reflect on past health inequity to cope with current work

	situations.
Illustration	“I think about the elders who fought hard for equality and we're still fighting today to close the gap and everything for health equality. I think that makes my job a bit easier because they had way worse than I have it now” p. 60.

Appendix VIII : JBI Grades of Evidence

Grade of Recommendations	Feasibility	Appropriateness	Meaningfulness	Effectiveness
A.	Strong support that merits application	Strong support that merits application	Strong support that merits application	Strong support that merits application
B.	Moderate support that warrants consideration of application	Moderate support that warrants consideration of application	Moderate support that warrants consideration of application	Moderate support that warrants consideration of application
C.	Not supported	Not supported	Not supported	Not supported