Building cultural responsiveness in a mainstream health organisation with '8 Aboriginal Ways of Learning': a participatory action research study

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Abstract

Objective: Despite much effort and goodwill, the gap in health status between Aboriginal and non-Aboriginal Australians persists. Bringing Aboriginal cultural protocols and teaching strategies into healthcare could improve the fit between healthcare services provided and Aboriginal peoples. This approach to making healthcare more accessible has not been tested in mainstream health settings. This study aimed to introduce '8 Aboriginal Ways of Learning' to a mainstream health organisation and observe how learning about Aboriginal perspectives and processes shaped work-related project or program design.

Methods: Program and network coordinators (n=18) employed in a state-wide health organisation joined in-person workshops and virtual sessions. Participatory Action Research methods guided the process and framework analysis transformed data.

Results: Introducing '8 Ways' generated conversations which went beyond deficits in Aboriginal health. Learning about cultural processes provided scaffolding to show how services and models of care can change.

Conclusions: This strategy demonstrated potential to improve approachability, acceptability and appropriateness of mainstream healthcare for Aboriginal peoples.

Implications for public health: Introduction of Aboriginal pedagogies were welcomed by mainstream healthcare workers as they provided scaffolding and support to plan and work in new ways. Future studies could examine outcomes on program design and access to services for Aboriginal peoples.

Key words: First Nations, Indigenous, qualitative research, health services research, Aboriginal ways of knowing, being and doing

Improving access to healthcare is a crucial element to improving equity in health outcomes for Aboriginal and Torres Strait Islander peoples.[1] One area that would benefit from ongoing dedication is improving the fit between the healthcare provided by organisations and how Aboriginal people feel about accessing healthcare. Previous work has shown that Aboriginal patients have described being excluded from healthcare due to judgement, blame, discrimination, stigma, prejudice, racism or poor communication.[1-6] This injustice has stimulated commitment to a wide range of plans,[7] policies[8] and workforce training and development strategies[9] to make access to mainstream healthcare fair for all.

Educating employees to be respectful of and responsive to cultural difference has a role in reducing racism in healthcare organisations,[5] with even a single session demonstrating a temporal effect.[10] In New South Wales, 35% of staff working across the public health system have completed 'Respecting the difference' mandatory online training with a small number completing the recommended local in-person training in 2013.[11] One South Australian study found that some non-Aboriginal staff perceived they did not know how to work with Aboriginal people or were fearful of getting things wrong or being unintentionally racist.[12]

While cultural awareness training has resulted in early indicators of educational impact and engagement and has created a solid foundation, there is little scaffolding to help non-Aboriginal health professionals' transition to culturally safe practice. Ongoing support for employees in terms of mentoring and critically reflective practice has been proposed to develop effective strategies and approaches to improve cultural responsiveness of health services.[12]

A potential solution is to bring strategies to the healthcare field which have proven successful in the NSW public education system. '8 Aboriginal Ways of Learning' was derived from the sharing of tens of thousands of years of accumulated cultural knowledge held by Aboriginal elders in north western NSW communities with Tyson Yunkaporta.[13,14] This resulted in an international award

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winning doctoral thesis,[15] and the founding of the Bangamalanha Centre, which continues to share this cultural knowledge across the NSW education system. The dissemination of '8 Aboriginal Ways of Learning' in mainstream education settings yielded improved engagement of Aboriginal students in education including record-breaking rates of Aboriginal students completing secondary school in the western NSW city of Dubbo.[16] Known initially as '8 Aboriginal Ways of Learning', it is now equally familiar as Aboriginal pedagogy.

Aboriginal pedagogy is based on a philosophy of relational responsibility (where people and relationships are the foremost priority) and emphasises that Aboriginal perspectives are found in the approach or the processes followed rather than the content.[14,15] Learning these cultural protocols (see Figure 1) gives explicit attention to Aboriginal ways of valuing, being, knowing and doing. Following cultural protocols in teaching and learning therefore embraces the cultural diversity within and between communities, resulting in culturally responsive pedagogy.

> *Culture is at the core of all thinking and learning. So if learning is your core business, then so is culture.*[14]

Based on the success in the education setting and the synergies between education and health, our research team discussed the potential of '8 Aboriginal Ways of Learning' to guide development of staff skills, values and critical reflection in a health context over several years. These conversations always involved Aboriginal and non-Aboriginal people, many of whom have become investigators on this study as our discussions turned to formal plans for research.

This study aimed to introduce '8 Aboriginal Ways of Learning' to a mainstream health organisation and observe how learning about Aboriginal perspectives and processes shaped work-related project or program design. Learning about Aboriginal processes was assessed for potential to improve Aboriginal peoples' access to mainstream health care using a conceptual patient and system access framework.

Methods

All investigators (five female and two male) were familiar with research principles and had experience introducing non-Aboriginal people to Aboriginal approaches, or experience working with Aboriginal people and communities on health-related projects or research. A strong relationship existed between investigators prior to commencing work on this study and discussions and preliminary work to introduce Aboriginal pedagogy to a health context had been explored for several years. Four of the seven investigators identify as First Nations peoples (three Aboriginal and one Polynesian).

The setting for the research was the Agency for Clinical Innovation (ACI), the lead agency for innovation in clinical care in NSW and a statutory health organisation.[17] The ACI brings patients, clinicians and managers together to support the design and implementation of innovation in healthcare. Staff commonly work in teams on health priority areas[17] resulting in well-established initiatives that follow cultural protocols led by experienced Aboriginal and non-Aboriginal staff (for example, Aboriginal Chronic Conditions Network,[18] Patient Experience and Consumer Engagement[19] and the Pain Management Network[20]). The organisational focus on clinical innovation positioned the ACI to explore how Aboriginal pedagogies might improve Aboriginal peoples' access to mainstream health services in NSW. The ACI brought collaborators together to design and undertake the study.

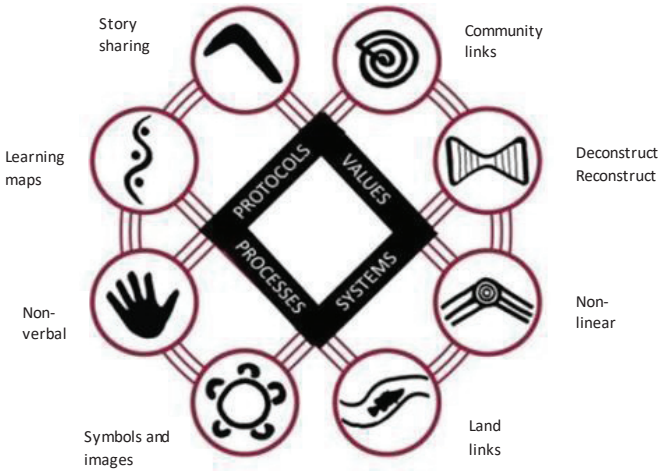
Our research team approached this study with an 'All Teach, All Learn' philosophy,[21] where each investigator is guided by the expectation of both sharing their knowledge and learning from other team members. Investigators from The Bangamalanha Centre shared knowledge of Aboriginal pedagogy, investigators from the Agency for Clinical Innovation (ACI) shared their clinical and health service knowledge and an academic from the University of Sydney shared knowledge of how the process could be studied so the potential of this approach could be shared with a wider audience.

A participatory action research design (where researchers and participants share power and decision making) was chosen for this study because of its tradition of empowerment, emphasis on collaboration and fairness, expectation of change and self-direction of participants to apply '8 Aboriginal Ways of Learning' on a real project related to their work.[22,23]

In November 2018 potential participants (n=29) attended an in-person 'meet and greet' session to hear what was proposed, ask questions and make suggestions. In February 2019 invitations to join the study were emailed to these potential participants. Twenty consented, including one participant from another state-wide public health agency who asked to be included. Two later withdrew (for external reasons).

Aboriginal pedagogy was introduced via a series of four workshops (WS) over four months (February to May 2019) with ten optional virtual (V) sessions in between. The workshops (led by AH and CS, supported by EW) were highly interactive. Didactic teaching about '8 Aboriginal Ways of Learning' was interspersed with small and large group discussion and direct application of the pedagogy to a work-related project. Teaching emphasised a strengths-based approach, encouraging participants to build on successes and to try new things. The virtual sessions were informal and designed to share

Figure 1: '8 Aboriginal Ways of Learning' (adapted and reproduced with permission).



ideas and problem solve (usually facilitated by EW supported by Aboriginal participants). Homework was set between workshops.

Data consisted of the following content: attendance numbers in workshops and videoconference sessions, workshop agendas, notes taken during all workshop activities including small and large group discussions, drawings produced during workshops or from homework and notes made during videoconference sessions. As data was collected during all these activities, participants had to consent to being part of the research in order to join the workshops.

Data from each workshop or virtual session was summarised (EW) and verified through discussion over a series of virtual (and some in-person) meetings with all investigators. During preliminary data collation and analysis, the research team identified that the data could be analysed using the supply and demand concepts of healthcare access.[22] A holistic conceptual framework, derived from work with Indigenous communities was identified.[25] The framework incorporates patient and service perspectives of the drivers behind access to care.[24] It had previously been applied to describe the unique qualities of Aboriginal community controlled primary care services, which enhance Aboriginal peoples' access to healthcare.[26] The five dimensions of access: approachability, acceptability, availability, affordability and appropriateness[24] were used to form a data extraction table. Data was comprised of curriculum delivered, summary data from workshops and virtual sessions, and tangible outputs (see Table 1) and each unit of data was added to the table. Once the framework analysis[27] was completed this was shared amongst participants for further discussion and refinement.

Aboriginal leadership was central to this project. A research governance group was convened and terms of reference developed with members. Intellectual Property generated from this research was shared between all parties. Ethics approval was received by February 2019 from both the NSW Aboriginal Health and Medical Research Council (1477_18) and Greater Western Health Research Ethics Committee HREC/18/GWAHS/106 (GWAHS 2018-098).

Results

Eighteen (n=13 women, n=5 men) in network manager and project officer roles completed the study. Workshops were well attended (n=16,16,13,14 respectively) as were virtual sessions (n=62 over 10 sessions). Participants were predominantly non-Aboriginal but included Aboriginal employees from the ACI who all made a significant contribution to the projects and research (during and beyond workshops and virtual sessions). Participant experience working with Aboriginal people and Aboriginal communities varied from none to leadership roles on successful projects.

Not all participants had a project in mind at workshop one. Some staff had commenced specific projects to bring to the '8 Aboriginal Ways of Learning' workshops, whilst others attended to learn about 8 Ways and apply the learnings to a project later. Projects were varied in nature, with examples including care of the high-risk diabetic foot, residential rehabilitation for drug and alcohol withdrawal, consumer enablement and treatment of hip fractures. Participants worked on projects as individuals (n=9), in pairs (n=3) and there was one group of three.

All eight of the 8 Aboriginal Ways were reported as being used when this was discussed in group reflection in workshop four. *Deconstruct/reconstruct* was applied to break down generic state-wide approaches and re-construct to include perspectives of Aboriginal patients and Aboriginal community leaders, which resulted in localising context and relevance of programs. *Community Links* helped participants identify Aboriginal people who should be consulted about projects. Existing networks were used to facilitate introductions and start discussions. This was relevant for both high-level governance and community-level meetings and demonstrated respect for cultural protocols. It also emphasised the importance of ongoing partnerships and bringing knowledge back to communities.

Learning maps were predominantly used to define concepts and visualise strategy. *Story Sharing* was used to clarify and define concepts and share content and was used in video, artwork, consultation and engagement. It was found to be a powerful tool in building understanding and empathy in non-Aboriginal people. *Symbols and images* were also used to define concepts and traditional artworks were used to convey messaging.

Land links were used in planning to define concepts (for example to emphasise that healthy feet provide the physical connection to Country). *Non-verbal* was used in design to emphasise key points. *Non-linear* informed the over-arching approach to project scoping and consultation.

Participation in the workshops and virtual sessions created a safe environment for conversations about and peer support for, integration of Aboriginal processes to projects. Conversations guided by '8 Aboriginal Ways of Learning' curricula changed the focus of discussions from the usual 'facts' about Aboriginal health to how to work with Aboriginal people. This opened new discussions about health outcomes which are usually framed in terms of deficits and behavioural determinants (weight loss, medication adherence, smoking cessation, exercise and the like) to bring discussion of social determinants of health to the forefront. Topics covered included self-determination, importance of culture, housing, education, employment and impacts of colonisation and racism. Discussions about Aboriginal community strengths such as sense of community, connection to and responsibility for each other and sense of humour and fun were also observed (WS2).

Reflective activities drew attention to the role a person's own culture plays in influencing decision making. This highlighted how decision making about health service design dominated by one culture could inadvertently exclude consumers who come from different cultural backgrounds (WS3). This brought forward new interpretations of familiar concepts such as considering health performance data such as 'did not attend', 'did not wait' and 'discharged against medical advice' as measures of cultural safety of a service rather than a deficit in health literacy on the part of the patient (WS1).

Peer support took the form of sharing success stories, asking for advice, encouraging and supporting each other to try new ways; and, sharing challenges when things did not go to plan.

> *Experienced staff shared success stories demonstrating existing organisational strengths to build on (WS1). Describing how attending to cultural protocols (reaching everyone, relationships, reflection) and shared decision-making drove successes.* (V4)

> *Asking advice from Aboriginal peers (V3, V5). Experienced colleagues helped design and trial approaches, explored cultural protocols, facilitated introductions to key informants (V1, V3) and sought Aboriginal co-facilitators (V8). Trying new ways of doing things such*

Table 1: Framework analysis summary showing 8 Aboriginal Ways of Learning curriculum, discussions generated and project outputs against five dimensions of service access.

Dimension of access	Curriculum delivered (workshops, virtual sessions, homework)	Discussion in workshop and virtual sessions	Outputs produced in workplace as a result of teaching, discussion and peer support
Stage 1 Approachability: perceptions of needs and desire for health care Patients perceive care is needed (includes health literacy and beliefs relating to health and sickness). Health services raise awareness of available treatments and services and provide care within community to raise profile of services.	*8 ways* • Deconstruct-reconstruct (WS1) • Community links (WS1) • Cultural protocols (WS1) • Story sharing (WS2 *Small group activities* • Making amends for intergenerational trauma (WS1) • How do we create an environment where Aboriginal communities want to seek health support and care? (WS2) • How do we help Aboriginal communities build on their successes? (WS2)	*Identifying changes which need to be made* Build a positive service reputation by consistently joining community activities (eg NAIDOC), work with Aboriginal workers to build community connections, ask elders for advice (WS2). Establishing and maintaining trust with Aboriginal communities is fundamental for service use (WS1-4) Improve patient awareness of services using role models and appropriate language. (WS2) *Peer support* Sharing success stories of working with communities. (WS2) *Conceptual shift*, working with communities is a legitimate way of doing business. Community links extend beyond staff and other organisations (these are stakeholders). (WS1)	REACH (raising worries with hospital staff about changes in a patient's condition)(28). Peers helped design and trial approaches and facilitated introductions to key informants to establish an advisory group. (V1) Over half of advisory group members were Aboriginal (V2). The group guided consultation processes including questions asked (V7) to bring local perspectives and develop the Aboriginal REACH resource. Consultation found common ground. When you deconstruct, this invites perspectives of patients and community leaders and reconstruct focusses on co-design of new way of working and articulates desire for innovation at the cultural interface. (WS3)
Stage 2 Acceptability: healthcare seeking (cultural and social factors influencing acceptability of the services for consumers and community) Patients have personal autonomy and capacity to seek care. Health services seek out and integrate cultural values and beliefs into the services they provide.	Description, explanation and modelling of cultural protocols eg. Welcome to Country (WS1) *8 ways* • Cultural interface (WS1) • Deconstruct-reconstruct (WS1) • Learning maps (WS2) • Symbols and images (WS3) • Non-verbal communication (WS3) • Land links (WS3) • Non-linear (WS3) *Small group activities* • Relationally responsive pedagogy (WS2) • Valuing the knowledge and skills Aboriginal people bring from home (WS2) • Which of the 8 ways did you use and why? (WS4) *Large group activities* • Presentation of learning maps (WS3) • Project presentations to senior staff (WS4) *Homework* • Reflective practice (WS1) • Cultural orientation worksheet (WS2) • Draw a learning map (WS2) *Distributed post workshop* • Online kinship modules[29] (WS2) • Personalised learning pathways from education (WS2)	*Identifying changes which need to be made.* Attending to cultural safety of the service and actively improving one's own cultural practice. Understanding values and ethics important to Aboriginal communities, having cultural guidance available. (WS2) A culturally safe space recognises expertise of Aboriginal people and acknowledges colonisation and genocide. Healing principles are included in the way services are provided. Interactions with healthcare providers are a two-way street and encourage relevant family members to be part of the interaction (WS2) Increase the Aboriginal workforce and support for Aboriginal workers including dealing with racism (WS1) Realising potential of Aboriginal Health Impact Statements (WS1) *Peer support*, sharing challenges when plans have not gone as expected and relationships soured (V9) Feeling trapped in 'health' western/ mainstream way. Difficult to change even when you want to. (V9) Asking advice from Aboriginal peers. (V3, V5) Trying new ways to collect information (questionnaire vs yarning) (V7) *Conceptual shift* Culture influenced decision making about service design which could inadvertently exclude consumers (WS3) Social determinants of health (self-determination, culture, housing, education etc) at the forefront of discussion rather than behavioural determinants (weight loss, medication compliance etc). (WS2)	Presentation of learning maps (visual project plans) demonstrated incorporation of 8 ways and understanding of cultural protocols (WS3) Final project plan presentations (WS4) examples project changes • Less linear thinking eg. diabetes and high-risk foot emphasise importance of healthy feet and physical connection to Country • Respect for cultural protocols • Focus on positives not just gaps • Building on to existing relationships, focus on trust • Workshops resulted in better definition and conceptualisation of initiative • Holistic program development including career pathways, time to build partnerships, system improvement and communication • Collecting information by yarning rather than surveys • Reflective learning shifted own thinking in so many ways
Stage 3 Availability and accommodation: health care reaching Access suitable for patient mobility, transport and communication Health service flexible delivery	No direct curriculum content	*Identifying changes which need to be made* Flexible service hours, telehealth, outreach, creative transport solutions (WS2) Increase health checks, health promotion, early intervention and development of health literacy (WS1) Less rigid rules eg. not blocking access to services when people fail to attend appointments (WS1)	
Stage 4 Affordability: Health care utilisation Patients can afford to access Health services assess full cost of care from patient perspective	No direct curriculum content	*Identifying changes which need to be made* Concern about lack of bulkbilling for general practitioner services and medical imaging and the way that waiting lists are generated (WS2) Ensure real costs of accessing services are considered (WS2)	

Table 1 cont.: Framework analysis summary showing 8 Aboriginal Ways of Learning curriculum, discussions generated and project outputs against five dimensions of service access.

Dimension of access	Curriculum delivered (workshops, virtual sessions, homework)	Discussion in workshop and virtual sessions	Outputs produced in workplace as a result of teaching, discussion and peer support
Stage 5 Appropriateness: Consequences of accessing health care (fit between services and clients need, including timeliness) Patients and communities maintain engagement with services Health services engage with communities to determine needs, plan, initiate, manage and govern activities locally. Care is holistic and assessed for effectiveness and quality.	*8 Ways* • Deconstruct/reconstruct (WS1) • Community links (WS1) *Small group activities*: • What is known about Aboriginal health? • Which community were you hoping to influence? (WS1) • How can we deliver quality services to Aboriginal clients? (WS2) • What would a successful community or program look like, feel like, sound like (WS3) • What's known about the gap, program objectives & actions (WS4) *Homework* Review Aboriginal Health Impact Statement,[30] mental health video[31] & social dets of health video[32] WS1 Consider own project • What 'gap' did you want to close? (& WS3) • What are your plans to work with community? • WS2 Consider an Aboriginal community. What impresses you as one of their successes?	*Identifying changes which need to be made* Health services need to be prepared to change service delivery. (WS2) A quality service is one used by Aboriginal people who keep coming back. CQI process involve Aboriginal people (WS2) Successful community programs emphasise the social (community, fun, engaging, busy, food, music), expression of culture (artwork, dance, stories) and community building (WS3) *Peer support*, experienced colleagues helped design and trial approaches, explored cultural protocols, facilitated introductions to key informants (V1 V3) and sought Aboriginal co-facilitators (V8) *Sharing successes*, story sharing by experienced staff demonstrated existing strengths to build on. (WS1) Describing how spending time attending to cultural protocols (reaching everyone, relationships, reflection) and shared decision-making drove success. (V4) *Conceptual shift*, health performance data could be interpreted differently. 'Did not attend', 'did not wait' and 'discharged against medical advice' could be measures of cultural safety of a service. (WS1)	Participant presentations acknowledging need for different approaches between western (documents and policies) and Aboriginal ways (protocols) (WS3) ACE (Yellow gum healing and regeneration) emphasised value of maintaining engagement (WS4) • It took time to build relationships, including that with the cultural advisor • First- protocols, values, systems, processes. • Used 8 ways as a framework for reflection for what has been done or not done and how to repair (relationships) when things did not go well. Invited an Aboriginal co-facilitator to join the program to help resolve program issues which seemed like deal breakers (V8) Key learnings: don't make assumptions, take time that is needed, stay strengths based and make sure you have Aboriginal liaison from the community from the start of the project. It was an emotional process, two steps forward, one step back.

as yarning style data collection instead of questionnaire. (V7)

Sharing challenges when plans have not gone as expected and relationships have soured (V9) Feeling trapped in 'health' western/ mainstream ways of working which are difficult to change even when you want to. (V9)

An '8 Aboriginal Ways of Learning' Community of Practice was established in late 2019 to continue peer support for the introduction of Aboriginal processes across the ACI.

A summary of the framework analysis demonstrating the mapping of curriculum elements, discussions this generated and project outputs across the five dimensions of health service access- approachability, acceptability, availability, affordability and appropriateness is shown in Table 1. This emphasises the potential of the '8 Aboriginal Ways of Learning' to change approachability, acceptability, and appropriateness of mainstream health services.

Discussion

This study successfully introduced '8 Aboriginal Ways of Learning' to project leads and network managers in a mainstream health organisation over a series of in-person workshops and virtual sessions. While the research team did not intentionally direct workshop concepts or projects towards Aboriginal healthcare access, it quickly became evident that access was the dominant health service delivery factor that projects sought to change. On reflection, this is unsurprising, given that culturally appropriate healthcare access is a substantial deficit in Australian healthcare and that the ACI's mission is to bring patients, clinicians and managers together to support the design and implementation of innovation in healthcare.

Learning about Aboriginal perspectives and processes generated critical reflection and conversations which went beyond deficits in Aboriginal health to provide scaffolding for participants to apply Aboriginal perspectives to a work-related project. Using a conceptual patient and system access framework in analysis demonstrated the potential of learning about Aboriginal processes to improve Aboriginal peoples' access to mainstream health care. Our study has started a conversation about how to build on the foundation of cultural awareness to bring sustained and meaningful change to mainstream health services to ensure access to health care and better health for Aboriginal peoples.

Australia has free universal health care. While this means all Australians have access to health care, in practice access is mediated by health system and individual, family and community factors in a dynamic and interdependent way. We chose a conceptual framework which considered access in an holistic way, emphasising that good access to care is achieved when a good fit between health services and patients is achieved.[24] Due to the emancipatory rather than prescriptive nature of the research we were unsure how participants were going to apply Aboriginal pedagogies and which factors of access this might mediate. Mapping data across the access framework demonstrated the influence of '8 Aboriginal Ways of Learning' on dimensions of access, notably approachability, acceptability and appropriateness of services. The next paragraphs explain how service access was strengthened by learning through Aboriginal pedagogies.

Approachability can be improved by raising the profile of available services and treatments in the Aboriginal community and by building a positive service reputation.[24] Participants in our study discussed and

trialled strategies such as joining Aboriginal community activities and working with Aboriginal staff to build community connections. Aboriginal pedagogies were used to deconstruct mainstream approaches and then reconstruct them, building in local Aboriginal community and service strengths. This engaged Aboriginal communities in understanding services which are available and resulted in development of culturally relevant material. Participants found this new approach to engagement straightforward to establish and reported a newfound feeling of legitimacy to working with communities.

Service acceptability can be enhanced when social and cultural values and beliefs are sought and integrated into health services provided.[24] Participants valued the cultural guidance given by their Aboriginal colleagues to negotiate and follow cultural protocols. They also valued the peer support and opportunity to share successes and challenges with Aboriginal and non-Aboriginal people. Participants actively improved their own cultural competence through reflective practice and formed a collective vision of a culturally safe organisation as one which systematically recognised the expertise and experiences of Aboriginal people and acknowledged both colonisation and genocide. Learning through Aboriginal pedagogy shifted the narrative from a biomedical to a social determinants of health approach, shaping design of individual projects. As an example, land links focused the importance of feet in being connected to Country for programs on diabetes and the high-risk foot. Participants described models of care focused on healing principles and work in a two-way exchange with patients and relevant family members in each healthcare interaction.

Appropriateness explores how health services engage with communities to determine their needs and to plan, initiate, manage and provide high quality services.[2]4 Participants learned about and were supported to follow cultural protocols to make local connections, establish relationships and build trust before projects were planned or initiated. Story sharing was used to define concepts and build understanding and empathy. Symbols and images were used to define concepts. Learning maps were used to describe plans. Community links were used to enhance reciprocity and return knowledge to communities. '8 Aboriginal Ways of Learning' also provided a framework for reflection to repair relationships when things did not go to plan. Working through project difficulties with communities resulted stronger partnerships between services and clients.

Cultural awareness can be taught but having knowledge about Aboriginal people and colonisation is insufficient to change the way non-Aboriginal people work with Aboriginal people and communities[12] or make services culturally safe.[26] Our study has demonstrated that learning through Aboriginal processes and protocols provides a scaffold that supports non-Aboriginal staff members to learn how to work with Aboriginal people and communities. The curriculum was responsive, flexible and delivered in a way that was readily accommodated by the organisation. Participants enjoyed the learning and increased their confidence and willingness to work in new ways, which generated innovative projects across a range of health disciplines and topics. These new skills and ways of working demonstrate enhanced capacity of the mainstream health workforce to create health services that improve suitability for Aboriginal peoples on the dimensions of approachability, acceptability and appropriateness.

This type of learning places a high level of responsibility on the learner, as emphasis on personal reflection and reflexive practice results in a personal journey. Progress relies on high levels of engagement and application from the learner. Given the personal investment made by learners it would be useful to understand how they apply Aboriginal pedagogies in future work (and perhaps life in general). Further research to understand ongoing use of '8 Aboriginal Ways of Learning' would increase understanding of the sustainability of taking this approach.

We have shown how '8 Aboriginal Ways of Learning' can be used to improve service fit from provider, but there is also potential for Aboriginal pedagogies to be used to engage patients as well. This was the case for one co-author who used knowledge of '8 Aboriginal Ways of Learning' to re-establish a therapeutic relationship with mainstream health providers. This approach has potential for future investigation.

Having projects in varying stages of development had no detrimental effect. While participants with projects in earlier stages were less able to critically reflect on their projects or ideas those in more advanced development were and this led to enthusiastic discussion and participation. There were changes to project governance across the life of the project but these were in keeping with key ethical principles for research with Aboriginal people.[33]

We are aware there are other mainstream health services in NSW introducing '8 Aboriginal Ways of Learning' into health programs and evaluating the effects. While these efforts are well advanced, they are yet to be published. Our study is the first to introduce '8 Aboriginal Ways of Learning' into a mainstream health context. We have presented details relating to the curriculum, summaries of workshop discussions and outlines of work-related projects undertaken by participants and discussed the potential of Aboriginal perspectives and processes to positively influence access to mainstream health services. A strength of this study was the conceptualisation and development took many conversations spanning years, which established relationships and trust within the research team. However, this was a small study consisting of one organisation with a small number of participants. In addition, some program areas within the organisation had previous success working in a culturally safe way so had a strong foundation and supportive staff to call upon, which may not be the case for other mainstream health organisations.

Conclusions

'8 Aboriginal Ways of Learning' proved readily adaptable to the healthcare context and has the potential to improve access of Aboriginal peoples to mainstream healthcare by improving the approachability, acceptability and appropriateness of healthcare. This approach was practical, feasible and fun and resulted in an increase in the number of culturally skilled and motivated staff who can collaborate and engage with Aboriginal people. The introduction of Aboriginal cultural processes and teaching practices were welcomed by mainstream healthcare workers as they provided scaffolding and support to plan and work in new ways. Future larger studies would allow examination of effects to cultural responsiveness and health service access for Aboriginal peoples.

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