An Evaluation of the Factors Affecting the Success of an Indigenous Community Based Healthcare Clinic: The Hands on Health Australia's Community Clinic, and Its Program—Aboriginal Health in Aboriginal Hands, at the Fitzroy Stars Football and Netball Club

A thesis submitted in fulfilment of the requirements for the degree of Master of Science

Sussen Stavridis

Bachelor of Applied Science/Health Science (Chiropractic) RMIT University
Bachelor of Animal Veterinary Bioscience La Trobe University

School of Health and Biomedical Sciences

College of Science, Technology, Engineering and Maths
RMIT University

November 2022

Declaration of Authorship

I certify that except where due acknowledgement has been made, this research is that of the author alone; the content of this research submission is the result of work which has been carried out since the official commencement date of the approved research program; any editorial work, paid or unpaid, carried out by a third party is acknowledged; and, ethics procedures and guidelines have been followed.

In addition, I certify that this submission contains no material previously submitted for award of any qualification at any other university or institution, unless approved for a joint-award with another institution, and acknowledge that no part of this work will, in the future, be used in a submission in my name, for any other qualification in any university or other tertiary institution without the prior approval of the University, and where applicable, any partner institution responsible for the joint-award of this degree.

I acknowledge that copyright of any published works contained within this thesis resides with the copyright holder(s) of those works.

I give permission for the digital version of my research submission to be made available on the web, via the University's digital research repository, unless permission has been granted by the University to restrict access for a period of time.

I acknowledge the support I have received for my research through the provision of an Australian Government Research Training Program Scholarship.

Candidate's Name: Sussen Stavridis
Submission Date: 08/11/2022

Cultural Sensitivity Warning

Aboriginal and Torres Strait Islander people should be aware that this thesis may contain references to or from deceased people.

ACKNOWLEDGEMENTS

I would like to acknowledge the people of the Woiwurrung and Boonwurrung language groups of the eastern Kulin Nations on whose unceded lands we conduct the business of the University. I respectfully acknowledge their Ancestors and Elders, past, present and emerging. I would also like to acknowledge the Traditional Custodians and their Ancestors of the lands and waters across Australia where we conduct our business.

My gratitude and appreciation extend to RMIT, my supervisors Professor Stephen Bird and Dr Dein Vindigni, my colleagues Dr Liz Pressick, Dr Dane Hone, HoHA team April Clarke, Franca Smarrelli, Simon Minton-Connell, Professor Mark Rose, Distinguished Professor Jon Adams, the Fitzroy Stars Football and Netball Club and its Community at Thornbury for their ongoing support and encouragement.

My husband Eleftherios Stavridis, my grandmother Nicoletta Stavridis and my father in-law Evangelos Stavridis not only supported me throughout this challenging journey through COVID-19 pandemic but helped shape this thesis to what it is now. They have continuously allowed me space and time to fulfill this degree by gifting me with the resilience, patience, and endurance I needed throughout.

Table of Contents

ABBREVIATIONS & Explanation of certain words

ACCHO—Aboriginal Community Controlled Health Organisation
AHAH—Aboriginal Health in Aboriginal Hands
AHPRA—Australian Health Practitioner Regulation Agency
AIHW—Australian Institute of Health and Welfare
COAG—Council of Australian Governments
Community—Signifying Indigenous Australian communities
Country—Includes all living things
Elder—Indigenous person who has custodian knowledge and lore and can disclose knowledge and beliefs
Gathering space—Culturally safe space that is welcoming, inclusive and has a sense of belonging
HoHA—Hands on Health Australia
HOPE—Hands on Philippines Education
Lore—Stories and customs learned from the dreamtime
NACCHO—National Aboriginal Community Controlled Health Organisation
NFP—Not for profit
PRISMA—Preferred reporting items for systematic reviews and meta-analysis
STTEP—Sustainable, Training, Treatment, Employment Program
WIL—Work integrated learning
6 Ls—Indigenous principles of engaging with Indigenous Communities
Five As—Dimension describing access to healthcare
First Nations Peoples— The first peoples of Australia. Throughout the thesis the interchangeability of words are used to describe Indigenous Peoples/participant. These include, 'Indigenous', 'First Nations', 'Aboriginal' and 'Aboriginal and/or Torres Strait Islander'.

List of Tables

List of Figures

SUMMARY

This research aims to present a summary of the health inequities between Indigenous and non-Indigenous Australians, suggest a list of important considerations that should be adhered to when delivering culturally appropriate health services and present the Aboriginal Health in Aboriginal Hands program as an example of a culturally appropriate allied health community service. Twelve years ago, a new model of allied health service provision (Aboriginal Health in Aboriginal Hands - AHAH) consistent with self-determination principles was collaboratively established by the not-for-profit charity organisation, Hands on Health Australia (HoHA). The aim of this program was to value-add to existing Medicare-funded and Aboriginal Community Controlled Health Organisation healthcare services by helping to further bridge the gap in the Community`s accessibility to allied and complementary healthcare services such as osteopathy, chiropractic, exercise physiology, Traditional Chinese Medicine and myotherapy. Anecdotal evidence to date suggests that this AHAH program has been well-received by both Aboriginal and non-Aboriginal members of the community. To better understand the factors affecting the delivery of culturally appropriate allied health services, a literature review was undertaken to identify and highlight issues. These were then points of consideration in the subsequent narrative review as well as the yarning sessions conducted with the developers and recipients of the program which considered the factors that may have contributed to the success and challenges of the HoHA program through how it accords with the 6 Ls' (Lore, Love, Look, Listen, Learn and Lead) and the 5 dimensions of access to healthcare (Approachability, Acceptability, Availability, Affordability and Appropriateness) that are deemed important by Aboriginal leaders and researchers in creating a culturally safe, appropriate and accessible healthcare service for Indigenous Australians. The HoHA—AHAH program demonstrates through the yarning sessions conducted with the developers and the recipients of the program, that this model value-adds to existing approaches to increase accessibility to healthcare services and continues to help in closing the health Gap.

CHAPTER 1: INTRODUCTION

1.1 Background Context

Indigenous Australians include Torres Strait Islander and Aboriginal people (1). Indigenous Australians comprise many groups that have their own cultural identities, beliefs, 'ways of knowing', languages and histories (1). To regard Indigenous people as a single, homogenous entity is therefore inaccurate (2). In 2020, The Australian Institute of Health and Welfare (AIHW) reported that Indigenous people make up 3.3% of the total Australian population, which is estimated to be 798,000 people, with a median age of twenty-three as compared to the median age of non-Indigenous Australians, which is thirty-eight years (1). A Lancet report in 2009 stated that Indigenous people have higher rates of mental, physical and emotional illness, injuries, disabilities and earlier and higher mortality rates than non-Indigenous people (2). The 'Health Gap' is highlighted by studies that have shown the various health conditions that contribute to this disparity, as well as the proposed reasons for the 'Gap'.

1.2 The 'Health Gap'

Social determinants of health does not only have a socioeconomic position, but includes other factors such as social supports, transport, food and housing (3). It has been stated that race, ethnicity and gender can also be socially constructed (3). The health status of an individual is intertwined and complicated by the 'multi-level' and 'multi-time point approach to social epidemiology', which includes, political economy, history, culture, discrimination, institutions, neighbourhood, community, work, friends, family, socioeconomic, psychosocial, behavioural, genetics, human biology and pathological biomarkers (3). All these elements come into play when the health 'Gap' is discussed between Indigenous people and their counterparts (3, 4).

In 2020, a report by The Australian Institute of Health and Welfare (AIWH) highlighted that one in three Indigenous youth will experience psychological illness at a very high level compared with one in eight of their non-Indigenous counterparts (1, 5). The AIWH also reported that chronic diseases make up 64% of the total burden of disease experienced by Indigenous Australians and that 19% of it is caused by mental illnesses and substance abuse disorders (1). An AIHW report in 2015 recorded that Indigenous people are 3.3 times more likely to develop diabetes, 1.2 times more likely to develop cardiovascular disease and 2.7 times more likely to use tobacco (6, 7). These diseases, and tobacco-use as a risk factor, account for more than half of the Indigenous 'Health Gap' (6, 7). Researchers have described an Indigenous 'epidemic of chronic lifestyle illnesses' which report that 40% of adults, and 60% of Indigenous people over the age of thirty-five have diabetes (2). Additionally, Aboriginal people aged seventeen years and younger are eighteen times more likely to be diagnosed with Type 2 diabetes compared to their non-Aboriginal counterparts (2, 8). These inequalities currently affect Australian Aboriginal people much more than other Indigenous groups around the world (2).

1.3 'Close the Gap'

It has been estimated that by the year 2030, the Australian Government will not be able to 'Close the Gap' in health inequalities between Indigenous and non-Indigenous people as per its original targets (9). With the aim of achieving health equality between Indigenous and non-Indigenous people, Professor Tom Calma championed the Social Justice report in 2005, which was the forerunner of what is now known as the 'Close the Gap' campaign (9). In 2007, the Council of Australian Governments (COAG) initiated the 'Closing the Gap' strategy, which articulated targets such as closing the life expectancy 'Gap' by a certain

timeframe. However, most targets have not been met by the proposed year, with statements by the COAG reviewed in 2016 and subsequently revisited in 2019 (9).

1.4 'Gap' pertaining to access to healthcare

As indicated above, many of the conditions that contribute to the health gap share modifiable lifestyle risk factors with their prevention representing opportunities for more general health benefits (6). Compounding these concerns is the prediction that the 'Gap' pertaining to accessibility to health care is expected not to be reached by its due target in 2030 (2). However, accessibility is not the only reason for this 'Gap'. Changes in culture, lifestyles and urbanisation, have also impacted Aboriginal Communities (2).

The negative impacts of urbanisation on Indigenous Communities over the last ten years were reported in 2009 by the Lancet (2). Urbanisation has been reported as contributing to major international public health problems associated with a decrease in physical activity, chronic lifestyle diseases, the introduction of Western diets, changes to infant feeding practices as well as overcrowding and contamination of the environment (2). These form part of the structural factors that influence the poor outcomes seen in 'Close the Gap' campaign. Structural determinants are known to play a significant role in informing social determinants (10). In part, these understandings illustrate why there are issues with the 'Close the Gap' campaign. Structural determinants such as limited or no promotion of self-determination, institutions predominantly aligned and set up for the dominant populations, deficit discourse and approach and a lack of decolonial approach are contributing factors to the poor outcomes seen (10). Self-determination is an 'on-going process of choice' to ensure that Indigenous Communities can meet their social, cultural and economic needs. It is not about creating a separate Indigenous 'state' (11).

1.5 Colonisation impacting 'Aboriginal ways of knowing'

The great disparities in disease and health statistics have been described as overwhelming when describing the health of Indigenous people throughout the world and Indigenous Australians in particular (2). What compounds these findings is that the mortality 'Gap' between Indigenous and non-Indigenous people is greater in Australia when compared to New Zealand, the United States of America and Canada (2). It has been reported that "the fabric of traditional societies was shredded by colonisation" and the impact of colonisation continues to contribute to the inequalities experienced by Indigenous Australians (2). Thus researchers, politicians Indigenous Elders and traditional Indigenous lore men and women believe that it is up to all Australians, to improve the impaired social and emotional wellbeing of Indigenous and non-Indigenous Australians for current and future generations (2, 12).

To effectively begin to address these issues, the participation and involvement of all levels of government, national/international agencies, health workers, not-for-profit organisations, health policy makers and administrators will be required (2). Most importantly, what is needed is full participation and engagement from Indigenous people to enable and empower them to help bridge the 'Gap' in health care (2). This is what underpins and helps exercise the right of self-determination (13). There must be a true understanding of Indigenous peoples' distinct political status, their right to make decisions and set priorities and continue to strengthen their institutions as well as protect cultural traditions and knowledge systems (13). We can therefore have a 'strength-based practice' rather than a 'deficit discourse' when relating to the 'Gap' and ways to bridge it in healthcare and health research (14). Another

important precondition for creating a positive impact in the lives of both Indigenous and non-Indigenous people, is to have a greater understanding of 'Aboriginal ways of knowing' (1).

1.6 Aboriginal ways of knowing

These 'ways of knowing' have been instilled over millennia as it is estimated that Aboriginal Australians have lived in this continent for approximately sixty-thousand years with more than two-hundred distinct languages and diverse groups each connecting to their 'Country' as a central part of their culture, customs and lores (1). In 2020, the AIHW reported that 63% of Indigenous people are involved in cultural events, organisations or ceremonies that continue to serve their health and wellbeing and contribute to a stronger sense of belonging and identity (1).

Central to the welfare of Indigenous Australians is the concept that their individual welfare depends on the wellbeing of their family and broader Community (1). A fundamental theme amongst traditional Indigenous Communities throughout Australia, despite cultural and geographical variations, was and continues to be that the greater good of the Community is paramount (1). This critically important cultural value was passed on from generation to generation through the traditional knowledge keepers; the lore men and women through ceremony, storytelling, performance, and language (1). Connectedness to Country, culture, identity, and leadership all have a role in Community life and are important ingredients for feeling safe, resilient, and fulfilled (1). Though mainstream health services attempt to manage some of the reported health inequities through the 'universal' Medicare system, the sociocultural and other determinants of health are usually inadequately addressed in these settings. Mainstream health services have historically and contemporarily failed to fully address the major lifestyle diseases affecting Aboriginal Communities (15).

Indigenous welfare is also widely reported to be influenced by social determinants such as housing, culture, access to services, education, employment, healthcare, community networks and safety (16). Other contributing factors include the person's attitude, knowledge, and health behaviours such as engagement, as well as services and support that are appropriate for their welfare (16). The negative impact of colonisation on the social determinants of health has been extensively reported (4, 5, 16-20). Though the disruptive and damaging effects of colonisation were reported as beginning in the seventeen-hundreds, there is strong evidence that their destructive consequences continue to exist today (4, 16-20).

1.7 Health Planning

There is clearly much to do to help `Close the Gap`. We need to know what the important factors in health planning are and the implementing strategies that may assist with attaining beneficial health outcomes for Indigenous Communities. A 2018 preliminary review of health planning for Indigenous Communities found that participatory approaches, in which health practitioners and Community members were brought together as part of a shared decision-making process represented potential best practices for advancing health planning and improving Indigenous health outcomes (21). It has also been well-documented that priority must be given to Elders when seeking advice and information from the Community (21-27).

Health planning for Indigenous Communities ultimately requires integrating Indigenous and non-Indigenous approaches to healthcare and management (21, 25). When collaborating to achieve a better understanding, Communities invariably uncover fresh viewpoints, opportunities and barriers and are more likely to create innovative opportunities for proactive

problem solving. Four factors have been described that need further research in relation to health planning (21). See Table 1.

Table 1. Factors in health planning (21).

4 FACTORS IN HEALTH PLANNING
1- Comprehending the 'Gap' between orality and literacy knowledge
2 - Database to advance and be accurate
3 - Building culturally safe management
4 - Respecting the importance of Elders in health planning

When Elders or Community members are involved in the health strategy process, one should also be sensitive to the history of traumas and injustice related to colonisation that may impact on their perspectives. Appropriate research frameworks and strategies that are culturally acceptable, namely Indigenist research paradigms (and principles), should be considered and implemented to ensure that Elders are equal partners in any decision-making process and not used as 'token' participants (21, 26-28). Rigney's approach to Indigenous research highlights the importance of research which is Indigenous led and privileges Indigenous voices with self-determination and emancipatory goals at its core (28).

It has been understood for many years that in Australia, 'racialized research industry' still exists (28), as it is the colonizers who have constructed the research methodologies and the 'protocols in knowledge constructions' (28, 29). This is why Indigenist research should be implemented by its three fundamental and interrelated principles; resistance to research with a colonial white lens to recognize and implement self-determination, political integrity which respects that research can serve and inform the political liberation struggle, and finally

privileging Indigenous voices (28-30). These types of qualitative methods in health planning assist in building open and honest conversations, trust, and empower the participants involved to produce better health outcome (21, 25-27). The not-for-profit organisation Hands on Health Australia (HoHA) was established in 1987 in response to an identified community need to help address disparities in the provision of allied and complementary care for people experiencing marginalisation or living in poverty (31).

1.8 Hands on Health Australia (HoHA)

The mission of Hands on Health Australia (HoHA) is to, "Enhance the lives of disadvantaged individuals and communities through a participatory approach to healthcare and wellbeing. The organisation aims to achieve its mission by; Engaging, Emphasising and Responding to people and communities in need (31). The HoHA services began approximately thirty-five years ago. It was established in 1987 at the Sacred Heart Mission in St Kilda and was inspired by the work of Mother Teresa and Moira Kelly AO in Calcutta, India. An important step in helping to 'Close the Gap' in healthcare is to support and continue to advance existing services provided by charitable organisations such as HoHA that deliver culturally sensitive, community-based, clinical and health promotion programs.

One such HoHA program occurs in collaboration with the Fitzroy Stars Football and Netball Club, known as the Aboriginal Health in Aboriginal Hands (AHAH) program. Culturally sensitive, allied, and complementary health programs such as AHAH are delivered in collaboration with members of the Community including Aboriginal health workers; coaches; Community mentors; and Elders. Participation at this level helps draw on the collective practical wisdom of Community members to facilitate holistic, integrated approaches to healthcare that may better address the socioeconomic and cultural contributors to health.

Apart from providing hands-on services in allied and complementary healthcare, community-based organisations such as HoHA may also advocate for the broader needs of the Community which include the physical, emotional, social and cultural wellbeing of the whole Community, enabling each person to reach their full potential as well as the 'total well-being' of the Indigenous Community (32). This is a 'whole-of-life' view that respects the concept of 'life-death-life' (32). This holistic understanding of health, though complex, ambitious and not readily embraced and funded by conservative, western models of healthcare is arguably more successful in its outlook and application/(32).

Contemporary models of funding healthcare including Aboriginal healthcare, have often used a 'body-parts' approach to health services and have often not consulted with nor supported the needs and aspirations expressed by the Community at grassroots (32). Funding is typically available as a single source that largely ignores holistic integrated approaches such as those that have been collaboratively developed and delivered at the HoHA clinic with the Fitzroy Stars Football and Netball Club (32, 33).

Another important prerequisite for attracting resources to sustain and grow health services of this kind, is the need for specific tangible health outputs or outcomes for individuals as well as clearly identified benefits and deliverables to the Community overall. The challenge is to develop key performance indicators that respect Indigenous cultural sensitivities and approaches to health care whilst creating reliable and valid indicators which do not constrain health service delivery (32). Another challenge is to find alternatives that may be more effective and cost-effective.

1.9 Hands on Health Australia (HoHA) and its Aboriginal Health in Aboriginal Hands (AHAH) program

Equipped with a deeper understanding of Indigenous Health priorities, as identified by Indigenous people, including the role of physical health and its connection with social, cultural, and traditional practices, we will be better placed to describe what the not-for-profit (NFP) organisation HoHA has delivered through its collaborative clinic at the Fitzroy Stars Football & Netball Club as part of its AHAH program in Thornbury, Melbourne, Australia. For the last seven years this HoHA program has been provided in a 'gathering space' which, though relatively basic in its facilities, has enabled members of the Indigenous sporting and general Community to receive culturally safe and respectful healthcare services including chiropractic (in the initial years) followed more recently by osteopathy, massage therapy, nutrition and Mental Health Care. Research describes key themes that arise from culturally safe gathering places such as: the provision of safe social networks that enable and encourage the learning and practice of culture; and feelings of inclusiveness, connection, belonging, and resilience (34). These places and programs may also empower some individuals to explore opportunities for leadership roles, and connection to culture and Country as critically important steps to rediscovering and strengthening one's identity (34). The importance of having Community clinics that provide this type of gathering space is illustrated here. Though this model of care may have the potential to be developed, and delivered in wider Indigenous Communities, the unique cultural needs and protocols of each Community need to invariably be understood, embraced and collaboratively driven prior to any program being implemented in keeping with the principles recommended by the National Australian Community Controlled Health Organisation (NACCHO) (35). These principles are also consistent with the reality that Indigenous Communities are not a single homogenous entity as stated above (2).

1.10 Indigenous Health Research

It has been widely reported that past research has often disregarded the wisdom and learnings of Indigenous experience, values, and participation, as it was applied with a 'white colonial lens' (25, 36, 37). Therefore, it is critically important to ensure that there is a 'shared understanding and collaboration' between Indigenous participants and their non-Indigenous counterparts when considering how to conduct any research (25, 36).

Qualitative research that integrates 'yarning' as a critical methodology, is culturally safe and maintains trustworthiness and credibility in research (36, 38). If we continue to recognise and prioritise the importance of enabling factors and barriers when planning research as seen in table 2, we are more likely to conduct research that ensures that these enabling factors are implemented and barriers are minimised as much as possible (36, 37).

Table 2. Enabling factors to promote versus barriers to avoid in qualitative research (36).

ENABLING FACTORS	BARRIERS TO AVOID
Comprehend cultural traditions	Not considering cultural differences
Networking with Community leaders	Poor healthcare service
Build trust and respect with the Community	Narrow concept of health and wellbeing

1.11 Allied health and complementary services at Hands on Health Australia

Allied health and complementary services that HoHA provide for the community, embrace an ethos of promoting well-being and sustainable healthcare via two models of care:

1. HoHA Work Integrated Learning (WIL) arrangements with tertiary institutions; and
2. Volunteer Led initiatives (39)

Hands on Health Australia has a longstanding history of creating culturally sensitive and responsive, community-based projects that support training for community members, collaborating with key community leaders and implementing enabling factors that help support these communities such as what has been described with Project 'HOPE' (Hands on Philippines Education) in 2009 (39). Project HOPE provided sustainable training, treatment and employment programs (STTEP) in poor Filipino communities by upskilling for community health workers in basic myotherapy. However, there is insufficient research that illustrates the impact that allied and complementary health services can provide to people experiencing socioeconomic disadvantage. Models such as HoHA's Sustainable training, treatment, employment program (STTEP), demonstrate the importance of managing musculoskeletal pain and dysfunction given its widespread impact on the community's economic, physical, social, and emotional well-being (40). More studies in different communities are needed to determine whether more people can benefit from these types of services in HoHA community clinics such as the Fitzroy Stars Football and Netball Club.

This research describes how HoHA programs have impacted on the Community's social, cultural, emotional, and physical wellbeing. It also explores, the need and potential to establish these HoHA programs in other communities to help increase the reach and health benefits for Aboriginal and Non-Aboriginal people. Whilst touching on the general HoHA model(s) of healthcare, this research will primarily focus on the impact of one HoHA program, Aboriginal Health in Aboriginal Hands, as well as the strengths, limitations, and learnings of these programs in promoting the health of Indigenous and non-Indigenous Australians.

A subsequent stage in this research project will comprise a critical review that will describe the various models of Indigenous healthcare that were historically developed and delivered in Australia. This will form Chapter 2 of the thesis and will include:

1. the ‘universal’ Medicare system, initially designed to care for the medical health needs of all Australians with an emphasis on those who for socioeconomical and geographical reasons were unable to access healthcare;
2. the National Aboriginal Community Health Controlled Health Organisations (NACCHOs) which grew in response to the self-determination movement; and
3. the Hands on Health Australia model which was established in 1987 in response to the lack of allied and complementary health services throughout Australia which were (and continue to be) mostly inaccessible to vulnerable communities and those experiencing marginalisation, including Aboriginal Communities.

Chapter two explores the various models of Indigenous healthcare and lays the foundation for Chapter three, four and five which use an overarching Narrative methodology, consistent with an accepted, widely utilised and scientifically rigorous approach to collaboratively developing, delivering and evaluating the impact of such programs in Indigenous Communities (41, 42).

The learnings and recommendations arising from interviews conducted in Chapters four and five may be used to encourage the adoption of the HoHA model in other Indigenous Communities.

To build on Indigenous health research for Communities, we aim to:

- Describe and understand the development, delivery and impact of the Hands on Health Australia—Aboriginal Health in Aboriginal Hands program at the Fitzroy Stars Football and Netball Club;
- Narrate the experience of Aboriginal and non-Aboriginal people who use the 'AHAH/HoHA' health services at Fitzroy Stars Football and Netball Club;
- Based upon the perceptions of the Community members and developers of the Hands on Health Australia, Aboriginal Health in Aboriginal Hands' program, better understand the factors that contribute to successful Community—based health services for Indigenous peoples;
- Raise awareness of the potential strengths and challenges in this program to investigate ways to refine its delivery and potentially generate more resources to expand the program`s reach and impact on Aboriginal Communities and,
- Identify characteristics of the service that contribute to successes that may assist in the delivery of other services.

The research questions are:

1. In the view of the developers of Hands on Health Australia, what have been the perceived successes of the Aboriginal Health in Aboriginal Hands program?
2. In the view of the Community members, what have been the perceived successes of the Aboriginal Health in Aboriginal Hands?
3. Based on the perceptions of the Community members and developers of Hands on Health Australia, what are the factors that contribute to successful Community-based health services for Indigenous peoples?
4. How does the Hands on Health Australia—Aboriginal Health in Aboriginal Hands model compare with other approaches to Indigenous healthcare?

5. Are there any limitations in the current model that may warrant refinement and/or improvement?

Due to the negative impacts of research on Aboriginal Communities, and its ineffectiveness when addressing Aboriginal health, Indigenous health research today must continue, to positively pursue carefully constructed ‘shared learnings’ between Indigenous and non-Indigenous researchers (43). Importantly, researchers must continue to develop the ‘research transfer and capacity development’ approach that Brands and Gooda discussed in their 2006 article on effective ways to conduct Aboriginal health research (43). This research also supports the ‘Bundyi Girri’ (shared future) project that the Royal Melbourne Institute of Technology University (RMIT) has led in order to build a new relationship between Indigenous and non-Indigenous Australians (44).

CHAPTER 2: DELIVERING HEALTHCARE IN A CULTURALLY SENSITIVE MANNER: A CASE STUDY OF HANDS ON HEALTH AUSTRALIA'S MODEL

Sussen Stavridis

Co-authors: Stephen Bird, April Clarke, Franca Smarrelli, Dein Vindigni, Mark Rose

Abstract

This brief report aims to present a summary of the health inequities between Indigenous and non-Indigenous Australians, suggest a list of important considerations that should be adhered to when delivering culturally appropriate health services and present the Aboriginal Health in Aboriginal Hands program as an example of a culturally appropriate allied health community service. Twelve years ago, a new model of allied health service provision (Aboriginal Health in Aboriginal Hands—AHAH) consistent with self-determination principles was collaboratively established by the not-for-profit charity organisation, Hands on Health Australia (HoHA). The aim of this program was to value-add to existing Medicare-funded and Aboriginal Community Controlled Health Organisation healthcare services by helping to further bridge the gap in the Community`s accessibility to allied and complementary healthcare services such as osteopathy, chiropractic, exercise physiology, Chinese medicine and myotherapy. Anecdotal evidence to date suggests that this AHAH program has been well-received by both Aboriginal and non-Aboriginal members of the community and has promoted their health and wellbeing. To better understand the factors affecting the delivery of culturally appropriate allied health services, a literature review was undertaken. The learnings from this review were used as points of consideration in the subsequent narrative review. This review considered the factors that may have contributed to the success and challenges of the HoHA program through how it accords with the 6 Ls' (Lore, Love, Look, Listen, Learn and Lead) and the 5 dimensions of access to healthcare (Approachability, Acceptability,

Availability, Affordability and Appropriateness) frame works that are deemed important by Aboriginal leaders and researchers in creating a culturally safe, appropriate and accessible healthcare service for Indigenous Australians.

Keywords: Indigenous, Australians, Healthcare, Healthcare Models, Allied Health, Complementary medicine, Conventional medicine, Aboriginal Community Controlled Health Organisations, Wellbeing, Community, Health Policy, Government funding

Introduction

The negative impacts of colonisation on the health and wellbeing of Indigenous people have been widely reported in the published literature (2, 16-18, 20). This includes how healthcare was and continues to be provided in Indigenous Communities (45) as well as the manner in which health-related research has historically been conducted. In more recent years, a push towards adopting decolonising models of health service delivery and healthcare research has allowed advancements in these areas through strategies that attempt to bridge the health gap between Indigenous and non-Indigenous communities (16, 21, 46). Working with and for Indigenous Peoples, respecting and using Indigenous knowledges, helps articulates the concept of decolonising models of healthcare research and service delivery (46). The Australian universal health care model (Medicare) was introduced in 1984 and followed the establishment of the Aboriginal Community Controlled Health Organisation (ACCHO) services in 1971 as part of the movement towards Indigenous self-determination (47, 48). However, despite these initiatives, significant disparities between the health of Aboriginal and non-Aboriginal people remain (45, 48) with the health disparities arising from access to healthcare treatment being apparent for most major illnesses including, cardiovascular disease, kidney disease and cancer (49). For example, when addressing the burden of cancer,

Indigenous Australians have poorer five-year survival rates and the mortality gap is widening. In contrast, this mortality rate has decreased by 16% for non-Indigenous Australians (50). Additionally, despite public health programs specifically designed to address cardiovascular disease, Indigenous Australians continue to have a 50% higher risk of mortality due to this illness when compared to non-Indigenous Australians (50). Consequently, the overall life expectancy for Indigenous Australians is approximately ten years less than their non-Indigenous counterparts (50). Additionally, there is a need to pursue and promote research reporting on musculoskeletal conditions affecting Indigenous people in Australia, as these are also reported to affect Indigenous people more than their non-Indigenous counterparts (51, 52).

Australian Universal healthcare (Medicare)

Universal healthcare was created to ensure that all Australians have access to the healthcare services that they need and care that they may require without financial hardship (53). Australia developed its universal healthcare (Medicare) system in 1984 to promote equity by enhancing affordability and accessibility of healthcare services (53). Medicare ensures free-of-charge public hospital admissions as well as subsidised healthcare services outside of the hospital. However, despite the aim and initiative to mitigate out-of-pocket expenses through Medicare, the costs of the program have increased over the years (53).

Aboriginal and Torres Strait Islander peoples' use of Medicare, as indicated by healthcare costs per person, has been reported to be only 39% of that for other Australians, despite Aboriginal people having three times the rate of economic, social, educational and morbidity disadvantage compared to non-Aboriginal people (54). The reason for this has been attributed to barriers including financial cost (such as out-of-pocket expenses), cultural issues, and

distance to services, all of which play a role in accessing mainstream services in Australia (55). Accessibility in this model of healthcare is still an ongoing, unresolved and under researched problem in Australia (56). Compounding this burden is the reality that the current Medicare model of healthcare does not recognise, subsidise nor deliver services that incorporate a recognition of cultural and wider social issues (57, 58). What is lacking in the current model of healthcare is an approach that helps address the health gap using integrated, multidisciplinary health services that are affordable, accessible, and delivered through culturally sensitive and socially responsive approaches (57, 59).

Contributing to this overarching discrepancy are inequities in access to ambulatory healthcare (healthcare services outside of the hospital setting), which are still apparent in Australia (56). In this field of ambulatory healthcare services, private health insurance allows better access to non-mainstream medical services (such as chiropractic, osteopathy, and Traditional Chinese medicine). However, given the financial costs of private healthcare, these healthcare services are still largely not accessible to disadvantaged communities, nor are they commonly available in culturally safe and familiar settings. This is a public health concern when it is widely reported that vulnerable communities including Indigenous people, have a higher incidence of chronic diseases than non-Indigenous people (48). Moreover, people who suffer from chronic diseases require multidisciplinary care which is difficult to attain when most of these services based on a fee-for-service (60), which further compounds the health inequalities between Indigenous people and their counterparts (56).

Therefore, there are growing concerns about the sources of inequity in Australian health care systems and there continues to be insufficient research on inequalities in terms of the access to and use of both ambulatory medical and non-medical services between people of higher

socioeconomic status and people experiencing socio-economic disadvantage in the community. This disadvantage applies to both members of Indigenous and non-Indigenous communities (56) with these issues exacerbated by the finding that vulnerable members of the community require more visits to a health care practitioner than their counterparts given their complex needs and higher morbidity rates (48). This combination of factors thereby contributes to Australia's acknowledged position of 'lagging behind other colonial nations in achieving Indigenous health equity' (61) making accessibility to the aforementioned services for Indigenous communities a national healthcare priority that has been recognised for many decades, but for which mainstream healthcare services have yet to Close the Gap.

Aboriginal Community Controlled Health Organisations - Self-determination movement

Aboriginal community-controlled health organisations (ACCHOs) were first established in 1971, primarily in response to continual poor access to health services as well as Aboriginal people facing discrimination in mainstream health care (48, 57). These services led to the establishment of a different model of primary care to address the health inequalities experienced by Indigenous people (48, 61). Within the healthcare model of ACCHOs, exists an allied health sector, which usually include health professionals from the disciplines of pharmacy, nutrition/dietetics, physiotherapy and optometry (59). However, other registered allied health services such as chiropractic, osteopathy and Chinese medicine have not historically been included, nor have myotherapy and massage therapy which are not currently registered health professions by the Australian Health Practitioner Regulation Association (AHPRA) (62). These under-represented health professions across the Indigenous healthcare spectrum, including ACCHOs contribute further to the gap in healthcare by limiting access to a diverse and holistic range of healthcare services in which healthcare professionals provide

essential primary health care to help combat the range of complex health issues that impact a Community's quality of life (63-72).

Literature review

An understanding of the gap pertaining to accessibility to other allied healthcare services was established by conducting a systematic review using the preferred reporting items for systematic reviews and meta-analysis (PRISMA) guidelines (72). The electronic database PubMed systematically searched for peer-reviewed articles published between January 1970 and January 2021 and searched again in April 2022, for articles published since the initial search. The purpose was to identify articles pertaining to ACCHO healthcare services that included either osteopathy, chiropractic, Chinese medicine or myotherapy. Based on the PRISMA guidelines, Figure 1 demonstrates the flowchart for selecting eligible articles.
The Boolean operators and keywords and medical subject headings relating to this discussion used were "Health Services, Indigenous"[Mesh] OR "Aboriginal health" OR "Aboriginal community-controlled health service*" OR "National Aboriginal community-controlled health organisation" AND "Complementary Therapies"[Mesh] OR "Complementary Therapies"[Mesh] OR "Allied Health Occupations"[Mesh] OR "Allied health" OR "Complementary medicine" OR "Alternative medicine".

Once the databases produced the articles that matched these terms, the titles and abstracts of the papers were screened to determine relevance before reading articles in full to be included or excluded depending on their relevance. Shown in Table 1, a review of the ten articles identified via this process indicated that none included the allied health disciplines of chiropractic, osteopathy, myotherapy, Traditional Chinese Medicine, exercise physiology or massage therapy being delivered at any Aboriginal Community Controlled Health

Organisation. Hence, given the absence of literature on the existence and delivery of these services via Indigenous healthcare approaches that integrate cultural sensitivities and appropriateness, the authors identified a need to address this deficit through their research.

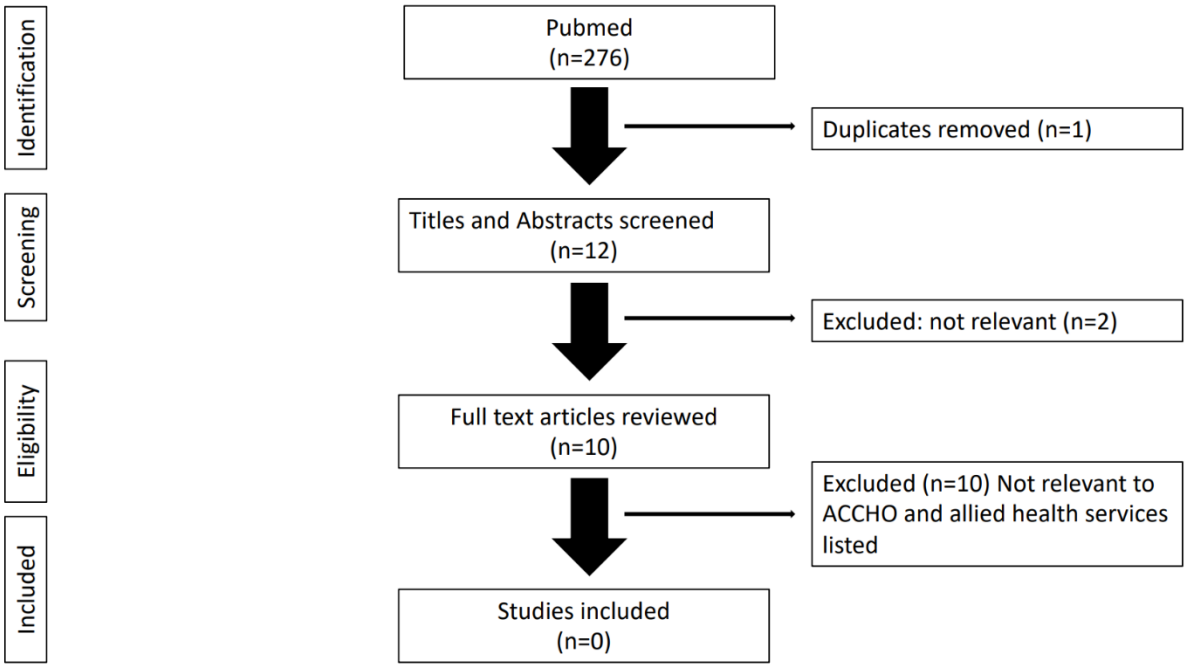

Figure 1. PRISMA flow chart of the literature search

Table 3. The articles that were reviewed from the literature search

Study	Study design	Type of healthcare	Location
Pidgeon F. Occupational therapy: what does this look like practised in very remote Indigenous areas? Rural Remote Health. 2015 Apr-Jun;15(2):3002. Epub 2015 Apr 26. PMID: 25912169.	Observational study	Occupational Therapist	Remote Northern Territory of Australia
Shahid S, Bleam R, Bessarab D, Thompson SC. "If you don't believe it, it won't help you": use of bush medicine in treating cancer among Aboriginal people in Western Australia. J Ethnobiol Ethnomed. 2010 Jun 23;6:18. doi: 10.1186/1746-4269-6-18. PMID: 20569478; PMCID: PMC2902429.	Qualitative study- Interviews using thematic analysis	Medical Cancer therapy with bush medicine	Remote and rural Western Australia
Vindigni D, Parkinson L, Walker B, Rivett DA, Blunden S, Perkins J. A community-based sports massage course for Aboriginal health workers. Aust J Rural Health. 2005 Apr;13(2):111-5. doi: 10.1111/j.1440-1854.2005.00664.x. PMID: 15804336.	Descriptive, pilot educational intervention study	Sports massage	New south Wales- Kempsey
Campbell D, Davies J, Wakerman J. Facilitating complementary inputs and scoping economies in the joint supply of health and environmental services in Aboriginal central Australia. Rural Remote Health. 2008 Oct-Dec;8(4):1010. Epub 2008 Oct 10. PMID: 18847299.	Review article	Joint supply of environmental and health services by a single provider	Central Australia
McFarlane K, Devine S, Judd J, Nichols N, Watt K. Workforce insights on how health promotion is practised in an Aboriginal Community Controlled Health Service. Aust J Prim Health. 2017 Jul;23(3):243-248. doi: 10.1071/PY16033. PMID: 28162218.	Qualitative cross-sectional survey	Aboriginal and Torres Strait Islander health workers and health practitioners, outreach midwives, podiatrists, audiologists, speech pathologists, physiotherapists, dieticians and nutritionists, diabetes nurse educators, health promotion officers, social and emotional wellbeing staff, paediatricians, general practitioners and corporate support staff	Queensland
Young C, Tong A, Gunasekera H, Sherriff S, Kalucy D, Fernando P, Craig JC Health professional and community perspectives on reducing barriers to accessing specialist health care in metropolitan Aboriginal communities: A semi-structured interview study. J Paediatr Child Health. 2017 Mar;53(3):277-282. doi: 10.1111/jpc.13374. Epub 2016 Oct 17. PMID: 27748557.	Qualitative semi structured interviews using thematic analysis	Specialist ear, nose and throat and speech pathology services	New South Wales- Metropolitan areas
Askew DA, Togni SJ, Egert S, Rogers L, Potter N, Hayman NE, Cass A, Brown ADH, Schluter PJ. Quantitative evaluation of an outreach case management model of care for urban Aboriginal and Torres Strait Islander adults living with complex chronic disease: a longitudinal study. BMC Health Serv Res. 2020 Oct 6;20(1):917. doi: 10.1186/s12913-020-05749-7. PMID: 33023589; PMCID: PMC7539491.	Quantitative research study	General practitioners and nurse case managers	Queensland
McDonald H, Browne J, Perruzza J, Svarc R, Davis C, Adams K, Palermo C. Transformative effects of Aboriginal health placements for medical, nursing, and allied health students: A systematic review. Nurs Health Sci. 2018 Jun;20(2):154-164. doi: 10.1111/nhs.12410. Epub 2018 Feb 2. PMID: 29392872.	Systematic Review	health profession* OR health occupation* OR health personnel OR health care worker* OR healthcare worker* OR physician* OR general practitioner* OR surgeon* OR allied health OR doctor* OR medical professional* OR nurs* OR dentist* OR physio* OR dietit* OR dietic* OR dietetic* OR speech pathologist* OR ophthalmolog* OR orthoptic* OR audiolog* OR occupational therap* OR optom* OR orthotic* OR podiatr* OR prosthetics OR pharmac* OR physio* OR podiat* OR psycholog* OR radiograph* OR social work* OR speech patholog* OR midwi* OR medical OR medic OR medics OR nutritionist* OR diabet* educator*	Australia OR Victoria OR Tasmania OR New South Wales OR Queensland OR Northern Territory
Wilson AM, Kelly J, Jones M, O'Donnell K, Wilson S, Tonkin E, Magarey A. Working together in Aboriginal health: a framework to guide health professional practice. BMC Health Serv Res. 2020 Jul 1;20(1):601. doi: 10.1186/s12913-020-05462-5. PMID: 32611413; PMCID: PMC7329497.	Qualitative study	Dietitians, occupational therapists, health promotion workers and speech pathologists	South Australia
Lin I, Green C, Bessarab D. 'Yarn with me': applying clinical yarning to improve clinician-patient communication in Aboriginal health care. Aust J Prim Health. 2016 Nov;22(5):377-382. doi: 10.1071/PY16051. PMID: 28442021.	Critical review	Doctors, nurses and allied health practitioners	Western Australia

Discussion

Dimensions to delivering healthcare in a culturally sensitive manner.

Access to healthcare is a complex notion which is compounded by differences in the many definitions of access to healthcare that have been described since 1971, all of which highlight its complexity and ambiguity (73). To address this, a dynamic and cumulative perspective known as the 'five A's dimension describing access to healthcare' framework was developed by researchers and is described in figure 2 (73).

Figure 2. Demonstrating the elements of access to healthcare through defining the five dimensions for access to healthcare and integrating the 6Ls model required for health and wellbeing.

The components of the five A's include: Approachability; Acceptability; Availability; Affordability; and Appropriateness. **Approachability** relates to services that can be reached due to transparency and information pertaining to existing services. Another element that

helps define the concept of Approachability is the ability to perceive a need for care that requires numerous factors such as, knowledge, health literacy and belief systems around healthcare and disease (73). **Acceptability** demonstrates how social and cultural factors determine one's ability to accept and receive services. **Availability** relates to the physical existence of healthcare services and resources characterised by facilities providing flexible opening hours and the presence of different health professionals. **Affordability** constitutes the capacity for people to spend time and resources to use healthcare services (73). **Appropriateness** illustrates the importance of a person's needs, quality of care, timeliness and the amount of care met by the healthcare services provided (73). It is thereby inferred that providing effective access to healthcare is complex and influenced by the combination of these interdependent dimensions. Such considerations extend to what ACCHOs, Medicare, allied and complementary health services can collectively and collaboratively offer to fulfill the 'five dimensions of accessibility to healthcare' framework, required to achieve effective and beneficial outcomes for Communities most in need.

Therefore, it is proposed that successfully bridging the health gap between Indigenous and non-Indigenous peoples requires effective strategies to access culturally appropriate and diverse healthcare services by implementing the five dimensions of accessibility in the provision of healthcare. Culturally sensitive considerations when attempting to integrate these allied healthcare services also include adopting well-established Indigenous principles of engaging with Indigenous Communities such as the 6 Ls - **Lore, Love, Look, Listen, Learn** and **Lead** to achieve individual and community wellbeing as described by Indigenous Elders (74).

Dimensions of the 6 Ls model are described below and included in figure 2: 'The 6 Ls is a model that demonstrates the relevance of the wisdom of the Old People in our modern world' (74). By listening to and learning from the 'wisdom of the old people in our modern world' when considering how to best integrate culturally sensitive and responsive healthcare we will be better placed to help bridge the health gap between Indigenous and non-Indigenous people (74). By way of illustration, an example of such an allied healthcare service (Hands on Health Australia (HoHA), and its program (Aboriginal Health in Aboriginal Hands (AHAH), is outlined in the remainder of this review and describes its alignment with both the five As and 6 Ls.

Case study - Hands on Health Australia (HoHA)

The purpose of Hands on Health Australia (HoHA) is to, "enable volunteers to provide healthcare and other services to communities, societies and people who are marginalised". It aims to promote health and wellbeing through a spirit of welcome and mutual respect by providing inter-disciplinary and inclusive healthcare, enabling volunteers to create a caring community that embraces all people (31).

The HoHA services began approximately thirty-five years ago. It was established in 1987 at the Sacred Heart Mission in St Kilda, Melbourne and was inspired by the work of Mother Teresa and Moira Kelly AO in Calcutta, India. HoHA delivers culturally sensitive, community-based clinical and health promotion programs guided by the following principles:

- healthcare is a basic right of life for all people;
- building relationships of trust;
- nurturing a sense of community and responding to individual needs;

- delivering the highest standards of care;
- striving to bridge gaps in healthcare;
- collaboratively responding to the needs identified by local communities;
- providing holistic health practices;
- working together with existing healthcare services and organisations that share a similar vision, values, and principles; and
- improving health outcomes that depend on accessible, affordable and culturally sensitive education at the individual, health-worker and community level (31).

One such HoHA program that adopts these principles has been delivered in collaboration with the Fitzroy Stars Football and Netball Club over the last seven years. It is known as the Aboriginal Health in Aboriginal Hands (AHAH) program. This culturally sensitive, allied, and complementary health program (chiropractic, osteopathy, Traditional Chinese medicine, myotherapy and massage therapy) is delivered in collaboration with members of the Community including Aboriginal health workers, coaches, community mentors and Elders. Participation at this level helps draw on the collective practical wisdom of Community members to facilitate holistic, integrated approaches to healthcare that aim to better address the socioeconomic and cultural barriers and contributors to health as well as meeting the five dimensions of access to healthcare.

Hands on Health Australia (HoHA) – incorporating key aspects of the five As and six Ls

The steps taken by members of the HoHA-AHAH program to achieve the five dimensions of accessibility to healthcare include actioning the model of the 6 Ls. The Hands on Health Australia-Aboriginal Health in Aboriginal Hands program demonstrates the importance of: being culturally informed (consistent with the elements of **Lore** and **Cultural**

Appropriateness), being deeply engaged (**Love** and **Availability**), volunteer led services (**Love** and **Affordability**), present and empathic (**Look, Listen** and **Acceptability**) and enabling the provision of multidisciplinary healthcare services that are not readily accessible in other Community clinics (**Learn, Lead** and **Approachability**).

The HoHA-AHAH program is delivered in a 'gathering space' at the Fitzroy Stars Football and Netball Club: Lore, Appropriate, Approachable and Acceptable

'The first step to well-being is understanding the importance of your place and the obligations to your place that you need to fulfill' (74). Implementing the Lore means to connect with Country and accept responsibility for Country as well, regardless of whether you identify yourself as an Aboriginal person or not (74). It has been understood that Appropriateness in healthcare services, not only denotes the fit between clients and services needed, but also relates to adequacy and quality, which means to offer a variety of healthcare services in a way that respects and aligns with cultural belief systems (73). Aboriginal Health in Aboriginal Hands fulfills the principles of Lore and Appropriateness through its healthcare clinic at the Fitzroy Stars Football and Netball Club. This is an Indigenous Community club which welcomes all people in the region by offering many different types of allied and complementary healthcare services in an open-space setting known as a 'gathering space' (34). These include weekly chiropractic, osteopathy, myotherapy and exercise physiology services that are not readily available via the Medicare system or at ACCHOs'. The open plan setting in this Indigenous Community club enhances the ability for Community members to gather and connect with place and Country as well as seek care in an environment that is culturally safe and welcoming (34). This environment is consistent with the concept of **Approachability** and **Acceptability** as Community members can identify services that exist and can be readily reached. thereby facilitating steps to promote their health. Through this

‘gathering space’, Community members may yarn and share stories that relate to obligations, morals, and responsibilities as well as sharing their own story. This ‘gathering space’ allows for stories to be safely shared, understood, and accepted which includes acknowledging the importance of the past. This is how the Lore is maintained, which is believed to provide well-being to individuals and thus the Community (74).

Love, Look, Listen, Affordability & Availability

Consistent with the chronology and steps described in the 6 Ls, the next critical component that AHAH fulfills is **Love**. **Love** from an Aboriginal perspective, embraces a strong spiritual conviction and altruism, relating to principles and goals, and incorporates obligation and commitment (74). Aboriginal and non-Aboriginal volunteers at AHAH understand and express **Love** by ensuring that the Community connected with the Fitzroy Stars Football and Netball Club receives healthcare in a non-invasive, welcoming, and respectful way. By appreciating the gaps in complementary and other allied health services, members of the AHAH team introduced free healthcare services to achieve the dimensions of **Availability** and **Affordability**. Not only does this program offer these healthcare services at the Fitzroy Stars Football and Netball Club but they also travel to other regions in Victoria. Chiropractic students and their clinical supervisors have regularly participated in the Ballarat Koorie Football Carnival by treating players on the field and being a part of the Community. The Indigenous coordinator of the AHAH program reflects that this program is “reconciliation in action” which enhances and helps fulfill the elements of **Availability** and **Love**.

To enable healthcare workers and volunteers to adopt the elements of **Love, Look** and **Listen,** the primary contact person, who is both the director and coordinator of the AHAH program, as well as a highly respected member of the Indigenous Community, carefully selects students and clinicians who are empathetic to the cultural needs and sensitivities of the

Community and provides them with further cultural awareness and proficiency training on Aboriginal ways of knowing, being and doing. Additionally, being a key person who is known and trusted by potential recipients of the service and with their presence helps to create a culture of, safety, sensitivity, and welcome to all. These are features that are directly seen by potential recipients of the service and experienced by those receiving ongoing treatment.

Similarly, the Board and Committee members of HoHA in collaboration with senior members of the Indigenous Community, enhance the culturally sensitive and responsive delivery of the service through priorities, policies and practices that are consistent with the needs and expectations of the Indigenous Community served and provided by the healthcare service.

This program is exclusively volunteer led, demonstrating the **Love** component of the 6 Ls model. Once having attentively listened to and observed (**Listen & Look**) the Community`s needs, people with a passion for giving, are better placed to provide effective, holistic allied healthcare to the individuals and their Community in this culturally safe and welcoming Melbourne suburban gathering space. In Uncle Paul Callaghan and Uncle Paul Gordon`s words, “By looking and listening to all that is around you, the world will become your classroom and your connectivity with the stories of the world will be limitless…” (74).

Learn & Lead

Integral to the 6 Ls model are the elements to **Learn** and **Lead**. which are intertwined with and dependent on **Looking** and **Listening**. As the AHAH program has unfolded, its developers and collaborators have continued to learn what is required to further enhance the

HoHA-AHAH program and how to **Lead** and promote a model of accessible healthcare that is genuinely sensitive and responsive to the healthcare needs of all members of the Community. An example of the **Learning** and **Leading** elements includes the collaboration between HoHA and Sports Medicine Australia which evolved from **Listening** and **Learning** to younger members of the Community as well as Elders about the need to create accessible pathways to participate in 'hands on' training courses to increase Indigenous students` knowledge, skills, and confidence in Sports Therapies. As part of this program, in 2019, twelve Indigenous students who were enrolled in the School of Health and Biomedical Sciences at RMIT University were supported to participate in two weekend courses leading to the Sports Trainers qualification required to work in this industry in Sports Clubs. The courses covered First Aid, strapping and sports massage. Of the twelve participants, several gained ongoing employments at the Fitzroy Stars HoHA clinic. As part of the spirit of inclusion, the courses were also open to other Indigenous students with an interest in Sports Training and or the `hands-on` therapies to increase the accessibility of this education and employment pathway. Furthermore, through delivery at the University, relationships between the Community and Indigenous education partners were enhanced and awareness of health pathways and opportunities highlighted.

Following graduation, most students who have completed their placement at HoHA-AHAH continue to engage respectfully with members of the Aboriginal community. Many graduates have asked to be connected to their local Aboriginal Community to provide ongoing treatments through their clinic or through ACCHO's. Some graduates have become teachers who have been approached about how they can better deliver Aboriginal perspectives at their schools. These are just a few examples of how the HoHA-AHAH program continues to help **Lead** and provided examples for creating relationships of trust and goodwill between

Aboriginal and non-Aboriginal people as well as promoting allied health as an educational and healthcare pathway for Aboriginal people.

Conclusion

Despite substantial efforts and achievements by ACCHOs and Medicare, in helping to bridge the health gap between Indigenous and non-Indigenous people, there continues to be a lack of accessibility to other allied and complementary health care services that are clearly under-represented and needed in Communities. The AHAH model developed and delivered by Hands on Health Australia provides new insights into how a program such as the one that HoHA collaboratively runs at the Fitzroy Stars Football and Netball Club in Thornbury, Melbourne, can further help bridge the health gap between Indigenous and non-Indigenous people both in Thornbury, and other Communities throughout Australia.

CHAPTER 3: RATIONALE FOR CHOICE OF METHODS

DESIGN OF THE STUDY

Introduction

This chapter outlines the research methods and the rationale for the selection of these methods for this project working with Indigenous people. Indigenous health research requires that certain methods be used to ensure safe, effective, and culturally acceptable ways to conduct research whilst maintaining validity and rigor. The methods have been selected and the study designed in consultation with members of the Indigenous Community and has been approved by the RMIT University Human Research Ethics Committee, which includes Indigenous members. The diagram created below outlines the methods used in this study to maintain credibility as well as ensuring ethical Indigenous health practices.

Figure 3. Illustrating the methodology used throughout this thesis

Study setting and context

The primary location of this study is at the Hands on Health Australia's Community clinic (HoHA) at the Fitzroy Stars Football and Netball Club, Thornbury, Melbourne from 2020-2022. Given the constraints imposed by the COVID pandemic, some interviews were conducted via the online TEAMS software.

Brief overview of the study design:

Using a Narrative Inquiry, this qualitative Indigenous health research study collected data using yarning methods and analysed the data thematically.

Rationale for Study Design

The inclusion of epistemological and qualitative approaches

Qualitative research methods are used in this study since they enable the deployment of various epistemological perspectives and different approaches which share a similar goal (75). Coming to a common understanding of a particular phenomenon from the experience of participants and forming solid findings and establishing meaning are the main goals of this approach (75). To ensure good practice when conducting contemporary qualitative Indigenous health research, one should appreciate the history of research for Indigenous people, how it was tied to the history of colonisation (76) and how it tends to reflect the scientific and social thinking of the past through a white colonial lens (28, 76). Therefore, research approaches continue to evolve and researchers try to find ways to conduct research

with a ‘post-colonial’ lens (28, 76). The current study acknowledges these realities and constructs this research using the ‘contested knowledge' theory. This states that research needs to bring knowledge and worldviews together in order to conduct ‘reconciliation research’ which draws upon Indigenous research paradigms, understanding that Indigenous epistemologies, worldviews and knowledge are productive, valid and even more appropriate elements when conducting Indigenous health research (16, 28-30, 77, 78).

Qualitative research

Qualitative research methods are used to capture non-numerical data to answer questions about perspective, meaning and experience from the standpoint of the participant (79). It is a suitable method for exploring and focusing on subjectivity as it is rooted in the ‘interpretative paradigm’ using scientific criteria to become research knowledge (80). In this approach, qualitative methods allow the evolution of new questions to be developed, with the aim of enhancing original knowledge by using inductive approaches utilising empirical data (80). This study uses qualitative methods to conduct practical and ethical Indigenous health research due to the understanding that qualitative research methods are shown to be culturally appropriate, productive, and useful for Indigenous people (81). This form of research allows Indigenous people to express themselves which gives Indigenous people a feeling of cultural safety (81). This study is researching participants involved with Hands on Health Australia at the Fitzroy Stars Football and Netball Club, based in the Aboriginal Community in Melbourne’s northern suburbs.

Narrative Inquiry

The proposed method of gathering this qualitative data will be via ‘Narrative inquiry’. Narrative inquiry has gained momentum over the last thirty years, now becoming a qualitative study design methodology in its own right (82). This methodology focuses on human experiences by telling stories, providing research with a rich framework through which we can investigate the ways humans see and experience the world through their narratives (82). Narrative inquiry is a suitable methodology when revealing unique perspectives, giving voice to marginalised populations. Narrative inquiry encapsulates and reveals the way people experience, act and live both as individuals and as communities and ‘narrative is our way of being and dealing with time’ (82). This approach reportedly resonates with Indigenous people and thereby validates the use of this methodology in this study, as the interconnectedness of narrative and human experience is looked upon as ‘forming meaningful connections to that life’(82). Indigenous members of Hands on Health Australia and its program Aboriginal Health in Aboriginal Hands believe this is the most appropriate method of gathering data for this project of both Aboriginal and non-Aboriginal Communities at the Fitzroy Stars Football and Netball Club.

Interviews

When conducting a Narrative inquiry methodology, methods to capture human experiences can come from surveys, focus groups, recording oral history and undertaking interviews. This study implemented the method of interview taking to capture participants' views and experiences when they had received HoHA—AHAH health services and those who helped develop the services. This method is the most used technique to gather ‘richly textured’ and

unique data. There are three ways to conduct interviews: structured; unstructured; and semi-structured. Structured interviews have a list of questions that are direct and set out to provide credibility and reliability although the responsiveness of the interviewees is limited. Unstructured interviews allow flexibility with no predetermined questions, however, the reliability of the data decreases. Semi-structured interviews reside between the two. This approach includes a list of questions and topics prepared in advance whilst allowing the interviewer to ask the questions in different ways with different interviewee/s. This type of interviewing allows flexibility and the responsiveness of the interviewee to be maximised as well as maintaining credible and reliable data to be collected (83-85). This study implemented semi-structured interviews using an Indigenous research method approach, known as 'yarning' as it was anticipated to enable Indigenous people to express themselves in a culturally safe and respectful manner by implementing a form of data collection that is both culturally accepted and appropriate (86).

Yarning

Yarning is an 'Indigenous cultural form of conversation' which relies on cultural protocols, expected outcomes and relationships (86). This means that when you are yarning with someone, you ensure establishing relationality as well as accountability between each other. It is understood that Westernised research often overlooks these concepts when conducting interviews with Indigenous Communities. Yarning is an ethical and culturally acceptable method of interviewing Indigenous people for conducting Indigenous health research (38, 87).

Yarning has been described as an age-old, Community-based problem-solving approach used by Indigenous Australians to talk through problems or issues arising in the Community to achieve consensus before collaboratively addressing these issues. As part of this yarning process, one-on-one, face-to-face, semi-structured interviews with Community members and non-Aboriginal participants in the HoHA and AHAH programs were conducted. Participants were invited to 'tell their story' about these programs in a culturally safe and supported environment (36, 38). Additionally, yarning is the most appropriate method of interviewing Community members as part of this research, as it is part of an Indigenous oral tradition that is widely used and understood by both Indigenous people and researchers (86). Yarning is also interwoven with 'deep listening' and 'story-telling,' two-way interactions, which are essential elements for capturing the essence of a person's experience (88). There are many different forms of yarning which have been described and applied in health research with Indigenous people (86).

'Research topic yarning' provides directionality and determines a beginning and end with an interactive and relaxed way of conversing. It is stated that the researcher and participant 'journey together visiting places and topics of interest' that pertain to the research study at hand (86). Gathering data through the use of 'research topic yarning' has rigor and legitimacy within the broader research community as it has a role in the triangulation of research data bringing about knowledge that is both accurate and meaningful (86). Other forms of yarning include: Social yarning; Family yarning; Therapeutic yarning; Collaborative yarning; Clinical yarning; and Cross-cultural yarning (38, 89). This qualitative research implemented a combination of Social, Research topic and Cross-cultural yarning methods to ameliorate

some of the cross-cultural research differences that may exist when non-Indigenous health researchers conduct Indigenous health research with Indigenous people (89).

Sampling and participant recruitment

Non-probability sampling method

A non-probability sampling method, a mixture of voluntary response, snowballing sampling and purposive sampling techniques was used for this qualitative study to capture 'richly-textured information' for the phenomenon under investigation (90, 91). This form of sampling technique was anticipated to yield an in-depth understanding and insight of people at the Fitzroy Stars Football and Netball Club, despite the limited resources and constraints of time without generalising it to the broader community (92).

This study included two participant groups:

1. People who helped develop and administer the health services at Hands on Health Australia-Aboriginal Health in Aboriginal Hands at the Fitzroy Stars Football and Netball Club; and
2. People who received the health services Hands on Health Australia-Aboriginal Health in Aboriginal Hands provide at the Fitzroy Stars Football and Netball Club.

Sample size

The suggested sample sizes for the two participant groups were n=4 (Group one) and n=8 (Group two) a total of twelve sample size interviewees for this project.

In qualitative studies there is no definitive answer to the question of how many participants suffice rather that sample size is determined by several factors including, practical, methodological, and epistemological issues (91). Based upon the criterion of 'informational redundancy', sample size for the health service recipients interviewed in this study was determined when no new information was generated by more samples. This means that to maintain scientific rigor, sample size of recipients is dependent on 'theoretical saturation' of the data (93, 94). For the participants who developed and administered the services, the sample size was dictated by the small pool available. As each participant`s contribution to the development of the AHAH program was unique. they were likely to describe unique experiences at the HoHA—AHAH program. Indeed, there appeared to be some distinctive roles amongst participants in the AHAH service. Therefore, data saturation was not a relevant consideration in this case rather the need for 'all key personnel' to be included and for all key roles be represented in the sample. Consequently, this group was purposely selected to cover the inclusion criteria and to interview key senior management people to cover the main aspects of the program HoHA—AHAH. These limitations are recognised and acknowledged here.

Recruitment

Participants recruited for this study were people who used the HoHA—AHAH health service at the Fitzroy Stars Football and Netball Club and people who helped develop the services.

Participants were informed of the study through social yarning, privately. Participants were recruited after they contacted the researcher expressing their interest in wanting to be involved in the study. A Participant Information Sheet that detailed the study was then shared with prospective participants who wanted to be involved via email or phone. Once a date and time was arranged to meet, informed consent was obtained verbally during the 'Social yarning' before the 'Research-topic' yarning began.

Inclusion Criteria

The inclusion criteria for Group one were:

1. People of the ages 18 years and older who were English speaking and able to provide informed consent; and
2. People who developed and administered the Hands on Health Australia services at Fitzroy Stars Football and Netball Club.

The inclusion criteria for Group two were:

1. People of the ages 18 years and older who were English speaking and able to provide informed consent; and
2. People who received the Hands on Health Australia healthcare services at the Fitzroy Stars Football and Netball Club in the last seven years.

Data Collection

Interviews:

Group one-Online

The yarning session started with a non-recorded 'social yarn' via TEAMS online. This was to create a welcoming, calm and culturally appropriate environment, in which information was shared about the interviewer and interviewee, to get to know each other and build a social relationship. This approach helped establish a comfortable space in which to share thoughts and opinions. After the 'Social yarn', came the 'Research-topic yarn'. Here the 'Participant Information Sheet/Consent Form (PICF)' was reviewed together with the participant to help uncover any concerns, further clarifications, or any questions the participant may have had. The participant had at least one week in which to read the PICF carefully to understand each section. Verbal consent was attained during this period. Recording of the session began with the first question asked and subsequently continued until the participant was happy to end the 'research-topic yarn' noting that there were no more additional comments to be made. After the 'research-topic yarning' session ceased, the researcher explained the next steps. These included the following:

1. Only the researcher who yarns with the participant would listen to the recording carefully a few times before transcribing it into a word document;
2. The transcript was sent only to the participant involved in the yarn via email; and
3. The participant was then able to review the transcript and confirm their consent to use their transcript for this project via written or verbal consent.

Group two- Face to face and/or Online

The yarning sessions began with a non-recorded ‘Social yarn’ via face-to-face interaction or via phone call from people who stated they were interested in taking part in this research. The yarning session with the developers of the program, were conducted in a calm, welcoming, culturally appropriate environment, in which information was shared about the interviewer and interviewee. This approach was implemented to build trust and create a better understanding about what this project was trying to achieve and to determine if they were still interested in participating. By creating a comfortable safe space whilst socially yarning, the ‘Research-topic yarn’ is more likely to emerge progressively and respectfully. The PICF was scheduled to be forwarded to the participant to read in advance (a week prior). The PICF was reviewed together with the principal researcher (Masters candidate) to enable a full understanding of the process, transparency and to create a space in which to uncover any concerns, provide further clarification and answer any questions by the participant. The participant was also offered another opportunity to consent verbally to determine if they were still willing to participate in this study. The recording of the yarn occurred before the first question was asked and continued until the participant was happy to end the ‘Research-topic’ yarn, noting that there were no more additional comments to be made. After the ‘Research-topic’ yarning session ceased, the researcher explained the next steps:

1. Only the researcher who yarns with the participant listened to the recording carefully a few times before transcribing it into a word document;
2. The transcript was sent only to the participant involved in the yarn, via email or a printout or via phone message; and

3. The participant was then able to review the transcript, edit, omit or add to the transcript before confirming their consent to use their transcript for this project via written or verbal consent.

Data analysis

Thematic Analysis-Inductive modality

In this study we wished to extract data and analyse it with a relatively low level of interpretation, therefore the use of thematic analysis was selected over grounded theory or hermeneutic phenomenology, which required the opposite (75). Thematic analysis is a method that has been recognised as being both methodical and rigorous, creating insightful findings and positively contributing to qualitative research (95). Apart from being a method that is more accessible for researchers, it reportedly provides perspectives that generate unanticipated insights by highlighting differences and similarities between participants (95). From this rich data, we summarised and analysed key features to construct a clear and organised report of findings. Conducting effective thematic analysis provided a trustworthy basis for guiding this project. This included six distinct phases to establish trustworthiness (95). Table below sets out each phase.

Table 4. Phases of conducting trustworthy thematic analysis (95).

Phase 1: Familiarising the data	Prolong engagement with the data by triangulating different data collection modes, documenting reflective and theoretical thoughts, documenting potential codes/themes that come to thought, storing raw data in a well-organised archive and keeping records of all data field notes.
Phase 2: Generating initial codes	Debriefing with peers, triangulating data, reflective journaling, using coding framework, audit trail of code generation and documenting meeting minutes.
Phase 3: Searching for themes	Triangulation of data, forming diagrams of theme connections and keeping detailed notes about hierarchies and development of themes and concepts.
Phase 4: Reviewing themes	Researcher triangulation, carefully examining themes and subthemes and testing for referential adequacy by reflecting on the raw data.
Phase 5: Defining and naming themes	Researcher triangulation, debriefing with peers, coming to consensus on themes and documenting and naming the themes.
Phase 6: Producing the report	Member checking, debriefing with peers, describing the process of coding and

	analysis in detail, describing the audit trail and reporting on the reasons for theoretical, methodological and analytical decisions throughout the project.

An Inductive analysis was chosen over a deductive method, given that the research was likely to produce new learnings versus those based on previous theories (75). After transcribing the interviews and reflecting on their themes, codes were generated using the software NVivo. NVivo is a computer assisted qualitative data analysis software that manages qualitative data of both transcripts and audio files (96). This software saves time, boosts accuracy and speed through the data analysis process (96). It does not analyse the data but manages and aids in the analytical process of data analysis.

Data interpretation

The emerging themes were considered and discussed in the context of the five dimensions of access to healthcare (5As) and 6L's models to ensure a culturally appropriate healthcare model, as well as in accordance with the Australian Institute of health and welfare`s framework on delivering culturally safe healthcare (73, 74, 97).

CHAPTER 4: YARNING SESSIONS WITH GROUP ONE

(Developers of the Hands on Health Australia (HoHA)—Aboriginal Health in Aboriginal Hands (AHAH) program)

Abstract

Background: It is well established that there is a significant health gap between Indigenous and non-Indigenous Australian people and despite the range of healthcare initiatives to address these differences, the gap remains. However, there are a variety of models and emerging approaches to delivering healthcare in Indigenous Communities that may complement existing approaches.

Aim: To describe the perspectives of Aboriginal and non-Aboriginal people who have helped develop and administer the Hands on Health Australia—Aboriginal Health in Aboriginal Hands program and healthcare services, at the Fitzroy Stars Football and Netball Club.

Methods: Yarning sessions (a form of semi-structured interviews) were conducted with four key members of the program. Yarning sessions took place remotely, using the TEAMS online software system and interview transcripts were analysed thematically.

Results: The analysis identified five major themes: (i) Culturally aware and appropriate healthcare clinic; (ii) Enhanced employment opportunities; (iii) Unique, holistic clinic highlighting socially inclusive care; (iv) Need further reach and wider impact; and (v) Communication barriers.

Conclusion: The Hands on Health Australia—Aboriginal Health in Aboriginal Hands program and healthcare services, at the Fitzroy Stars Football and Netball Club facilitated healthcare access by providing services that are not readily available. These were delivered at

no-cost to strategically address multiple barriers to the Community`s accessibility of culturally sensitive allied and complementary healthcare services. Participants in the study believed that the program was established and delivered in a culturally appropriate manner and continued to provide accessible healthcare that enhanced the Community's health and wellbeing.

Key words: Indigenous health services; allied health; complementary health; community health

Background

The disparities in the health of Indigenous people throughout the world and Indigenous Australians in particular, have been described as ‘overwhelming’(2) . What compounds these findings is that the mortality ‘Gap’ between Indigenous and non-Indigenous people is greater in Australia when compared to New Zealand, the United States of America and Canada (2).

What is already known about this topic:

1. The significant disparities between Indigenous and non-Indigenous Australians persist despite initiatives to address Indigenous health and wellbeing through different healthcare programs (98);
2. There are multiple socio-economic and cultural barriers to accessing health care for some Aboriginal families (98); and
3. Access to healthcare is complex and involves many dimensions and levels that need to be recognised (59).

Introduction

As outlined in chapters 1 and 2, it is well established that there is a significant health gap between Indigenous and non-Indigenous Australian people and despite the range of healthcare initiatives to address these differences, the gap remains (2, 18, 99, 100). However, there are a variety of models and emerging frameworks for delivering healthcare in Indigenous Communities that may complement existing approaches. Seven years ago, a new model of allied health service provision (Aboriginal Health in Aboriginal Hands—AHAH) consistent with self-determination principles was collaboratively established by the not-for-profit organisation, Hands on Health Australia (HoHA). The goals of this program were to value-add to the existing Medicare and Aboriginal Community Controlled Health Organisations` services by helping to bridge the gap in the Community`s accessibility to allied and complementary healthcare by introducing services such as osteopathy, chiropractic and myotherapy. These healthcare services are not readily available in Aboriginal Communities for a range of socioeconomic and sociocultural reasons.

The aim of this study was to investigate the perceptions of the developers and administrators of HoHA`s AHAH program to determine their views of the important features of the services they provided and whether these enabled access to healthcare for Indigenous people at the Fitzroy Stars Football and Netball club. Furthermore, their perceptions regarding the strengths and limitations of the program were discussed as well as any suggestions for how the services could be improved.

Methods

Participants

Participants were recruited from those who developed and administered the services from the HoHA—AHAH program at the Fitzroy Stars Football and Netball Club. The researchers used purposive sampling to ensure all 'key personnel' had been invited to participate and that all key roles could be represented in the sample. This group was purposely selected to ensure that key senior management people were included to describe the main features of the HoHA—AHAH program. Ethics approval for this study was provided by RMIT University's Human Research Ethics Committee (Project ID 23249).

Data Collection

The researchers developed a yarning session guide based on meetings with a research advisory group which included: an Indigenous Elder; the club coach; the AHAH clinic coordinator; the CEO of Hands on Health Australia and the supervisory team for this research study. The yarning session guide included open-ended questions to facilitate discussion between participants and researchers. This demarcated a "Research-topic yarning session" which differed from the "Social yarning" performed before and after the "Research-topic yarning session".

The following questions were included in the yarning session:

1. What has been your experience of the clinic and healthcare program provided by HoHA at the Fitzroy Stars Football and Netball Club?;
2. What do you perceive to be the strengths or benefits that this service brings to you and other members of the Community?;
3. Do you feel there are any limitations or weaknesses with the clinic or its health services?;

4. Do you have any suggestions for how the clinic, or its services could be improved?;
5. Any other comments?

One-on-one yarning sessions (semi-structured interviews) were conducted between July and September 2021, using the online platform, TEAMs software system. Participation was voluntary and all participants provided verbal consent before being interviewed and written consent for their data to be used in this study. Participant recruitment ceased when all key personnel had been included and all key roles were represented. Yarning sessions were video recorded via TEAMs and transcribed.

Data analysis

Thematic-inductive analysis was used to analyse the data. One researcher independently read the transcripts and coded the data to inductively identify emerging themes and three researchers met regularly to discuss the codes to develop a preliminary coding structure. Transcripts were imported into NVivo, a software system used to code qualitative data. Each participant received their full transcript and was invited to provide feedback on whether it accurately represented their expressed views during the interview.

Results

Of the five participants invited to participate, four were interviewed. Non-participation was mostly due to time and scheduling conflicts, such as their needing to attend to other unexpected priorities and clashing meetings. All yarning sessions were conducted via the online TEAMS software system. Participant characteristics are provided in Table 5.

Table 5 Participant characteristics

Characteristic	*n*
Gender	
Male	2
Female	2
Aboriginal	1
Non-Aboriginal	3
Senior HoHA/AHAH administrator	3
Senior Fitzroy Stars Football and Netball Club administrator	1

The analysis identified five themes: (i) Culturally aware and appropriate healthcare clinic; (ii) Enhanced employment opportunities; (iii) Unique, holistic clinic highlighting socially inclusive care; (iv) Lack of reach and impact; and (v) Communication barriers.

The emerging themes and subthemes are described below.

Themes were coded and categorised according to the strengths and limitations of the program.

Key findings demonstrating the strengths of the HoHA/AHAH program were:

1. Culturally appropriate healthcare clinic;
    a. Adaptable and flexible
    b. Continuously meets Community needs
    c. Highlights the importance of building trust and relationships
    d. Constant development to improve access- integrating digital platforms
2. Enhanced employment opportunities by developing sports therapy courses;

3. Wholistic unique clinic highlighting social inclusion care
    a. Positive experience
    b. Great spirit/love
    c. Tackles loneliness

Key findings demonstrating the weaknesses of the HoHA/AHAH program were:

1. Need further reach and wider impact;
    a. Need better collaboration with general practitioners and Aboriginal Community Controlled Health Organisations (ACCHOs)
    b. Lack of allied healthcare service availability due to limited days and times
    c. Limited resources due to lack of government funding
2. Communication barriers;
    a. Between student practitioners working in the program and clients
    b. Between student therapists working in the program and coaches

The following section provides examples of the responses provided under each of the themes.

Strengths of the HoHA/AHAH program

1. Culturally appropriate healthcare clinic

All participants felt that the HoHA/AHAH program was a culturally appropriate healthcare clinic. Participants also described the AHAH program as adaptable and flexible, endeavouring to respond to the Community's needs especially amongst those who experienced disadvantage.

"From the beginning, it was very much taking time to listen and learn, taking one little step at a time and to be led by the wisdom of the Elders and the Community across the board."

"This clinic fills the gap of having a Community clinic that is in a setting that is culturally and spiritually aligned with Aboriginal people."

"Aboriginal culture orientation was essential and a necessity for students to learn and understand the Community."

"We were flexible, and able to chop and change time, including longer hours or coming in earlier…"

"Because it is a communal space…It isn't an isolated treatment room…which brings another level of feeling safe to be in this communal space getting treated."

Through strong relationships with Elders of the Community and engaging in advisory committee meetings, the HoHA/AHAH program has built trust and adapted to the needs of the Community during the challenging circumstances experienced in the COVID-19 pandemic.

"An informal advisory committee evolved which included the head coach and coaches, CEO, trainers and the patron coming together and responding to the needs of the Community and the services they represented."

"Yes, we need to talk about digital connectivity…Another way we can improve our services is to be able to get the Community in an online room…And in that way, providing certain workshops and inductions to make sure that, even if we are closed, then we only closed physically, but we are open 24/7."

2. Enhanced employment opportunities

A participant highlighted that the HoHA/AHAH program is not just a treatment-based clinic, but also provides training courses to further enhance Indigenous students' employment opportunities and skills.

"Sport therapy training courses provided by HoHA-AHAH has enhanced employment opportunity and skills and knowledge especially for Indigenous students-little steps moving further in the role of hands-on healers."

3. Unique wholistic clinic highlighting socially inclusive care

Some participants explained how this clinic differed from other community clinics, and that these differences were worth embracing as they strongly focused on ways to combat loneliness and social exclusion, which are major determinants of mental and physical health issues (101).

"It is a different type of clinic…non-judgemental, not threatening, warm… people feel they are home…I guess what I am saying is that the clinic is a holistic clinic."

"The clinic is also a pathway and a very healthy pathway, to ensure social inclusion and to ensure people never feel lonely… if anything, we are a social prescriber in a way we can connect them to outside of what the clinic offers."

"And by the time they come out of the room, you can see their bodies already dropped down. In a good way, they are relaxed, feeling safe and well when they leave and the evidence of that is when they come back."

Another participant described their positive personal and professional experience at the HoHA/AHAH clinic, stating that despite the lack of resources the environment had a great spirit and participants felt privileged to be a part of this service.

"Despite the space being cold and sparse, the environment had a great spirit…I feel personally extremely privileged to be of some service to the longest, continually surviving Community on earth."

Limitations of the HoHA/AHAH program

1. **Need further reach and wider impact**

Participants reported some limitations with the HoHA/AHAH program. Each allied health service was only available once per week and some members of the Community expressed a wish for the service to be more frequent to better serve their needs. Participants also described a lack of financial resources and poor collaboration with Aboriginal Community Controlled (ACCHOs) organisations and general practitioners, which are considered essential elements for improving access to healthcare.

"Despite the Community expressing a wish for the service to be available more frequently, it is currently operational one day per week and economic restrictions mean that this is not likely to increase in the short or medium term."

"We need to be in partnership with the other ACCHOs and Elders, so the more united we are, the better in working towards a common goal, then each organisation will have its role to play within the vulnerable groups."

"It would be a great help to have a like-minded GP on site as a 'gatekeeper' and member of the interdisciplinary allied health team. The GP might also be able to provide referrals to qualified allied health professionals who could work on-site and expand the availability and accessibility of the services."

"We need more funding and full-time workers in order to scope creep and reach those other targets that are really important."

4. Communication barriers

One participant described students' communication skills with Indigenous people and the head coaches of the Football and Netball team as a limitation that needed addressing and improvement. There had been times when the head coaches felt there was a lack of communication in relation to athletes' injury profiles and treatment plans, as well as a language barrier between some students and Indigenous people seeking care. Another reported communication barrier was the way in which pre-treatment screening was performed by certain allied healthcare students and led to miscommunication due to a lack of understanding of medical terminologies. Further student education on Aboriginal culture is needed to better equip students to communicate effectively and sensitively.

"Students speaking about things or the way they speak about treatments and conditions to the Community can be petrifying for some due to miscommunications…students need more education on how to speak to our Community…Better communication between the head trainer/coach and the students about the athletes' conditions and change in game play…There are pre-treatment questions that get too much…feeling interrogated. We have had boys never return again because they got terrified with what some students were saying

in regard to their complaint, or they felt they were interrogated…Need to prepare the students better to communicate well with the Community."

Discussion

Access to healthcare remains a challenge within the Aboriginal Community (59, 97). Lack of appropriate healthcare service provision for Indigenous people remains an important social determinant of ill health (59, 102, 103). We identified features of the HoHA-AHAH that led to increased access to allied health care services and programs that are holistic, unique, culturally aligned, and appropriate for the Community. Service shortfalls, such as the need to increase the frequency of health services, were also highlighted in this study. These shortfalls decreased the reach and impact of the program. Finally, communication barriers were described as areas requiring improvement.

Strengths identified in HoHA-AHAH program

- *Culturally aware and appropriate healthcare clinic*

Echoing the available evidence (97), participants stated the importance of having healthcare services that were culturally sensitive, safe, and aligned to meet the needs of the Community. By being aware of and responsive to Indigenous Australians' cultural perspectives, the HoHA-AHAH program is also consistent with the Australian Institute of Health and Welfare 'cultural safety in healthcare for Indigenous Australians: monitoring framework' for delivering culturally respectful healthcare services (104).

- *Enhanced employment opportunities*

Acknowledging that employment is another determinant of health, and that employment discrimination also brings negative psychological effects which reduces access to healthcare,

it is important to continue to encourage and proactively support community health organisations such as HoHA-AHAH that promote employment opportunity (2).

- *Wholistic unique clinic highlighting social inclusion care*

Whether it is perceived, or quantifiable, social isolation and loneliness are both associated with early mortality (98). Community organisations must be at the forefront of combating this under-recognised health crisis, as it is in these areas where most people that are disadvantaged experience social isolation or loneliness (98). The HoHA-AHAH is a unique example of establishing a 'gathering space' that allows many people to be treated in the same space where they can share stories and experiences that combat social isolation and loneliness.

Limitations identified in HoHA-AHAH program

- *Need further reach and wider impact*
- *Communication barriers*

With regards to the weaknesses found in this study, it is apparent that access to healthcare, particularly the element of "Availability", needs to improve to reach more members of the Community and create a better impact on the Community's' wellbeing (59). As we have mentioned in Chapter 1, "Central to the welfare of Indigenous Australians is the concept that their individual welfare depends on the wellbeing of their family and broader Community". In relation to communication barriers, this may be due to the distrust that some Indigenous people feel as well as cultural differences between Indigenous and non-Indigenous people (51, 99). In fact, it was acknowledged that communication difficulties are the main reason why Indigenous people in Australia choose not to access care for their musculoskeletal pain (51). This barrier is significant to the HoHA-AHAH program as one of the allied health

services main purposes is to provide culturally sensitive access to care for musculoskeletal pain. Distrust may create a communication barrier, so continuing to build respectful relationships with the whole Community and club will be paramount in overcoming the weaknesses of the program, reported in this study (20). There has been a rich body of research that has helped the Australian Institute of Health and Welfare publish a report in 2013 and revised in 2021 to improve the accessibility of health services in urban settings, such as this clinic at Thornbury, Melbourne for Indigenous People (105). Strategies acknowledged in the literature to help combat the need for further reach and impact as well as communication barriers are to continue to provide services locally and around areas that are close to Indigenous Communities, provide transport services for people who cannot or choose not to access or use the public transport facility near the clinic, 'use home visitation as part of a multi-faceted engagement strategy' and employ more Indigenous health workers and health professionals to continue to promote culturally safe service delivery (105). This in return will maintain the self-determination principles HoHA model of healthcare delivery works to uphold and enhance for the Indigenous Community in Thornbury, Melbourne Australia.

Study Limitations

This study presents a qualitative evaluation of the HoHA/AHAH program and its model. The results are based on the perspectives of the senior administrative team who developed this program and its health services. This is a potential limitation of the study as it is unknown whether the attitudes of other Community members, people who did not participate in the study, would differ from the findings presented here. Another limitation of this study is that the sample size was dictated by the small pool available. Each participant in this group developed or administered the services differently and therefore had unique experiences at the HoHA-AHAH healthcare clinic. Therefore, data saturation was not an appropriate

determinant, rather a subjective determination that ‘all key personnel’ would be included and all key roles represented in the sample.

Conclusion

The Australian Institute of Health and Welfare published a review stating that there are clear effective approaches that may improve outcomes for Indigenous people and can be associated with long-term benefits for their health and wellbeing. These included holistic approaches in healthcare, active involvement of Indigenous Communities in each stage of a program`s development and delivery, valuing cultural beliefs and Indigenous knowledge, employing Indigenous staff as well as clear plans for research and evaluations to identify successful aspects of programs and amendments to any shortfalls (106). The developers of the HoHA/AHAH program explained how this program and its model meets these characteristics and how it continues to evaluate and refine its program to ensure long-term benefits for the health and wellbeing of the Community.

Given the persistent health disparities between Indigenous people and their non-Indigenous counterparts, value-adding to Community health services may enhance access to healthcare and provide a successful strategy to improve Aboriginal health outcomes (49, 107). Programs such as HoHA—AHAH offer a potential framework to achieve this goal. While this program requires more awareness and commitment from policy makers, the burden of the health gap between Indigenous and non-Indigenous people in Australia may provide an incentive to invest in progressive and innovative health initiatives to help close the health gap. This healthcare clinic model highlights the importance of culturally competent services needed to overcome the barriers that many Aboriginal families continue to face when accessing health care.

Whilst it is essential to focus on strategies to close the health gap between Aboriginal and non-Aboriginal people, ensuring Aboriginal Communities have unimpeded access to diverse health care services with demonstrated effectiveness, cost-effectiveness, cultural safety, and sensitivity should also be a priority for policy makers (107). The HoHA—AHAH program demonstrates that this model value-adds to existing approaches to increase accessibility to healthcare services and continues to help in closing the health Gap.

CHAPTER 5- YARNING SESSIONS WITH GROUP 2

(Recipients of the Hands on Health Australia (HoHA)- Aboriginal Health in Aboriginal Hands (AHAH) program)

Abstract

Aim: To describe the perspectives of Aboriginal and non-Aboriginal people who have received healthcare services at the Hands on Health Australia-Aboriginal Health in the Aboriginal Hands program, at the Fitzroy Stars Football and Netball club.

Methods: One-on-one yarning sessions (a form of semi-structured interviews) were conducted with eight recipients. Yarning sessions took place at the Fitzroy Stars Football and Netball club and online.

Results: The analysis identified five themes: (i) Accessible and affordable healthcare clinic; (ii) Culturally appropriate healthcare clinic; (iii) Wellness healthcare; (iv) Need to further enhance culturally aligned healthcare; and (v) Need for greater reach and wider impact.

Conclusion: The Hands on Health Australia-Aboriginal Health in Aboriginal Hands program and healthcare services, at the Fitzroy Stars Football and Netball Club facilitated improved healthcare access by providing services that are not readily available as a no-cost service to strategically address multiple barriers to accessibility of culturally sensitive allied and complementary healthcare.

Key words: Indigenous health services; allied health; complementary health; community health

Introduction

As outlined in chapter one and two, it is well established that there is a significant health gap between Indigenous and non-Indigenous Australian people and despite the range of healthcare initiatives to address these differences, the gap remains (2, 18, 99, 100). However, there are a variety of models and emerging approaches for delivering healthcare in Indigenous Communities that may complement existing approaches. Seven years ago, a new model of allied health service provision (Aboriginal Health in Aboriginal Hands - AHAH) consistent with self-determination principles was collaboratively established by the not-for-profit charity organisation, Hands on Health Australia (HoHA). The goals of this program were to value-add to the services provided by existing Medicare and Aboriginal Community Controlled Health Organisations by helping to bridge the gap in the Community`s accessibility to allied and complementary healthcare such as osteopathy, chiropractic and myotherapy.

The aim of this study investigated the perceptions of the recipients of HoHA-AHAH to assess their views of the important features of the services they provide and how these enable access to healthcare for Indigenous people at the Fitzroy Stars Football and Netball Club. Furthermore, perceptions regarding the strengths and limitations of the program were discussed as well as any suggestions for how the services could be improved.

Methods

Participants

Participants were recruited from people who received services from HoHA and its AHAH program at the Fitzroy Stars Football and Netball Club. A mixture of voluntary response and

snowballing sampling techniques were used. Ethics approval for this study was provided by RMIT University's Human Research Ethics Committee (Project ID 23249).

Data Collection

A yarning session guide was developed based on meetings with the research team. One-on-one, face-to-face or online, yarning sessions (semi-structured interviews) were conducted between the start of April and the end of July 2022 at the Fitzroy Stars Football and Netball Club. The yarning sessions guide included open-ended questions to facilitate discussion between participants and researchers. This demarcated a "Research-topic yarning session" which differed from the "Social yarning" performed before and after the "Research-topic yarning session".

The following questions were included in the yarning session:

1. What has been your experience of the clinic and healthcare program provided by HoHA at the Fitzroy Stars Football and Netball Club?;
2. What do you perceive to be the strengths or benefits that this service brings to you and other members of the Community?;
3. Do you feel there are any limitations or weaknesses with the clinic or its health services?;
4. Do you have any suggestions for how the clinic, or its services could be improved?;
5. Any other comments?

Participation was voluntary and all participants provided verbal consent before being interviewed as well as written or verbal consent for their data to be used in this study. Participant recruitment ceased when there was a sufficient amount of people recruited with

the time constraints imposed by the study. Yarning sessions were audio recorded and transcribed.

Data analysis

Thematic-inductive analysis was used to analyse the data. One researcher independently read the transcripts and coded the data to inductively identify emerging themes, and three researchers met regularly to discuss the codes to develop a preliminary coding structure. Transcripts were imported into NVivo, a software system used to code the qualitative data. Each participant received their full transcript to obtain feedback and written or verbal consent to use their data in this study.

Results

A total number of eight participants were interviewed. Participant characteristics are provided in Table 6.

Characteristic	*n*
Gender	
Male	3
Female	5
Aboriginal status	
Aboriginal	6
Non-Aboriginal	2

The analysis identified five themes: (i) Accessible and affordable healthcare clinic; (ii) Culturally appropriate healthcare clinic; (iii) Wellness healthcare; (iv) Need to further enhance culturally aligned healthcare; and (v) Need for greater reach and wider impact.

The emerging themes and subthemes are described below.

Themes were coded and categorised according to the strengths and limitations of the program.

Key findings demonstrating the strengths of the HoHA/AHAH program were:

1. Accessible and affordable healthcare clinic;
    a. Accessible in relation to location of the clinic
    b. Affordable healthcare
    c. Welcoming space
2. Culturally appropriate healthcare clinic;
    a. Positive experience using the clinic
    b. Community outreach programs
    c. Open plan setting-gathering space
3. Wellness healthcare;
    a. Promotes preventative healthcare.

Key findings demonstrating the weaknesses of the HoHA—AHAH program were:

1. Need to further enhance culturally aligned healthcare;
    a. Be more trauma informed
    b. Initial consultation time is too long
2. Need for greater reach and wider impact;
    a. Lack of allied healthcare service availability due to limited days and times
    b. Need for more funding to enhance the clinic setting
        i. Facility does not cater for mums or aunties with children
        ii. More privacy for those who may need it
        iii. Better resources and equipment

c. Need to collaborate with local Aboriginal Community Controlled Health Organisations to reach more people
d. More advertisement to reach more people

The following section provides examples of the responses provided under each of the themes.

1. Accessible and affordable healthcare clinic

All participants felt that the clinic was welcoming, comforting and culturally aligned. The clinic was accessible due to its location being at the Fitzroy Stars Football and Netball Club as well as being close to public transportation.

"Look, I feel comfortable. It's a comfortable space. It's you know, I mean, it's cold, it's loud, you know, but it works for us. It works for the Community you know. It is about being comfortable knowing the people…It makes you comfortable, which is kind of like home if that makes sense…This more 'open door policy', …makes everybody feel welcome"

"It's the students as well. That they are really good kids. Very welcoming and they are not judgmental."

"You know, she is a real draw card for people because she is just so welcoming and connecting…I feel very comfortable using that space…very welcomed…doesn't feel foreign to me. So I just think all of those things just give me an extra level of comfort."

"...I was really impressed by just the accessibility of the service. I really liked the fact that…anyone was able to walk in….it was available to anyone and that sort of really appeals to my sort of social justice…"

"But I love the fact that it's in Croxton Hall, it is accessible, it is welcoming, it is very low key and not threatening."

"Accessible…you know Thornbury is a bit of a hub for us…so I think it just benefits all of the working mobs too, not just the residents locally."

"It is accessible and affordable for mob that cannot afford to travel or have financial stress"

"I think it is a good spot…location wise…the transport is right there. Can access it easily."

"...But I could never really afford it because of the cost. So that was probably one of the main reasons why I loved it. Affordable."

2. Culturally appropriate healthcare clinic

Participants expressed their positive experiences using the health services, noting the open plan setting was culturally appropriate as it was a 'gathering space' for their Community. They spoke about the community outreach programs HoHA delivered, reaching more people in a culturally appropriate way.

"They help me identify the problems I have and basically give me some home exercises which have helped till this day…"

"Strengths are that it works. The clinic fixes the problems that develop through football not only to keep me playing but fix me so I can function as a family member for my family"

"No I think it's got really nice people. And then when they are doing stuff to you, whatever you need to have done they take the time to actually explain it to you"

"Yeah that is sort of hand on health. It is not just theoretical I think…it is actually a really practical service…It is really supporting grassroots Community"

"Good communication and students and supervisors communicate respectfully. You know mob just shy away from going and getting treatment done because they are not being heard or being listened to…"

"I have seen the clinic do some follow up work and I was lucky enough to go down to Bruthen…offering their services to the community there after the bushfires"
"Other strengths are that they go out to the carnivals and you get so many more people learning about these services and trying it out which raises awareness and reaches out to more of our Community"

"He wouldn't do this program anywhere outside…like the mainstream services…whereas here he just goes. No one has to go with him…because it is his Community. He is not going to be judged…for him it is a familiar place and space."

"I walk in the door and think who am i going to know, yeah, you know, it is a really good feeling"

"The space, it's not warm or anything…it's a community space"

"Open plan setting. It is not something that you see often in clinics. And I didn't know how I would go with it. But you know what? I think it just melts away. Yeah. And you feel just so engaged."

"I love just like, you know, see that collaboration and guidance and that learning from each other."

"Connection I was able to have, run into mob who were there and could have a bit of a yarn. It's a meeting place, sometimes running into people you haven't seen in ages."

3. Wellness healthcare

Some participants expressed that the clinic not only helped with health concerns but promoted wellness care which they found to be very important to maintain health and prevent disease.

"…And it wasn't just a one off. Quick fix. They are very structured, very long term. Very thorough and detailed, wasn't just you know here's a quick treatment off you go."

"Encouraged preventative healthcare, maintenance care, getting checked every week even if there was nothing wrong."

"Promoted preventative healthcare, which is important with Aboriginal mortality gap. Do not wait until something is wrong, but get checked before something happens, especially for our young population."

"It has provided me with wellness care keeping me well and supporting my health"

4. **Need to further enhance culturally aligned healthcare**

A couple of participants expressed their concern relating to long initial consultation time which can deter Aboriginal people seeking care, as well as needing the students to be more trauma informed to ask questions that are more culturally sensitive.

"...So I would like to bring clients up, but I think the initial assessment is just too many questions and my clients get questioned enough. But I think the initial assessment is too much for them and also the fact that the initial assessment is done with other people."

"Yeah, especially when you change programs or you start a new term, you have to do it again (initial assessment)"

"So if we can streamline the time consuming initial assessment"

"Consult time is too long-time constraints, could it be better streamlined, like using digital health records instead of paper, as it can get lost."

"...I have heard them ask other people…have you experienced trauma? And so I think, when students ask that question, they are talking about physical trauma. But when you ask that to

people, trauma can mean intergenerational trauma unfolding other stuff, and child sexual abuse and family…they need to be a little more trauma informed."

5. **Needs for greater reach and wider impact**

All participants expressed their concern about the lack of reach and therefore impact. Participants felt that there needs to be more advertisement and reach to other community centres to help raise awareness of these health services and reach more people. They also expressed concerns about the lack of resources, and availability that constrain reaching more members of the Community.

"You know, look, don't get me wrong, Koorie grape vine right. Great. But I think it needs a little bit more than that."

"Probably one thing…more advertisement, awareness. And going out there to say these are the clinic services, these are the times, come on over…"

"Have it more clear they are open…"

"I think about sometimes the publicity of the messaging of the services is lacking…Just think there could be so many more people who I know would love it"

"Confused what people and services are offered sometimes, better education on the types of services available…lack of reach to people outside of footballers netballers."

"Getting more awareness to Community, GPs, VACCHO, VAS, ACHHO, relaunch get-together offering yarn, coffee and tea"

"Need more resources to get the word out, as the mob still thinks this service is just for players"

"Also need to show the mob and community that each round of students gets educated culturally and are hand selected to show respect"

"More flyers out to show what this service means and who can use it"

"More funding for better facilities to care for mums and aunties"

"Better resources for new massage tables, towels, equipment"

"Better resources to offer private spaces…some people might think they would like privacy"

"Have more times available for chiropractic services"

"More advertisement and connect with Aboriginal organisations in the area to help advertise this clinic"

"Connect with other community centres like VACCHO so we can expand the reach and get all the mob that need care to come down…"

Discussion

Access to healthcare remains a challenge within the Aboriginal Community. The researchers identified several features of the HoHA—AHAH program that led to increased access for Aboriginal and Non-Aboriginal families which included accessible healthcare service that was appropriately located, affordable and culturally aligned and acceptable. Identified shortfalls were that it still needs further reach and therefore wider impact as well as a need for further education to better equip students to offer culturally competent healthcare services for Aboriginal people.

Addressing Access to Healthcare for Indigenous people

Access to healthcare has been widely researched since 1971 as it is known to be 'central to the performance of healthcare systems around the world (73). However Indigenous Australians have suffered with absent or inappropriate health services since the 1960s (108). Some important barriers that have limited this Community from accessing healthcare services have been cultural inappropriateness, financial issues as well as distance of healthcare services (55). Using the principles of the five dimensions of accessibility to understand access to healthcare as discussed in chapter two, we can see this program was perceived to deliver healthcare services, meeting the dimensions of approachability, acceptability, availability, and affordability (73). Adding to this definition of meeting access to healthcare, we should also consider the Indigenous principles of engaging with Aboriginal Communities as discussed by senior lore men, Uncle Paul Callaghan and Uncle Paul Gordon explaining the elements of Lore, Love, Look, Listen, Learn and Lead, the 6 Ls model, which are needed to achieve not only individual but also Community wellbeing as understood and experienced by Indigenous Australians (74). The results of the yarns capture most of the 6Ls model as well

as the 5A's access to healthcare illustrating that this program delivered at Fitzroy stars Football and Netball Club does deliver culturally appropriate healthcare.

Wellness healthcare

Major health problems faced by many Indigenous people relate to lifestyle diseases such as obesity, diabetes, hypertension, cardiovascular diseases and chronic renal disease (2). Adding to this burden, some Indigenous people also suffer from malnutrition, social problems such as misuse of alcohol and other drugs as well as deaths associated with cigarette smoking (2). These health concerns were again highlighted when research published in 2022 reported that Indigenous people are more likely to suffer from these issues than non-Indigenous people (109). Apart from providing musculoskeletal healthcare, The AHAH program is also designed to provide wellness as well as preventative healthcare helping to support the Community with ongoing health concerns and promote self-care strategies to increase physical activity and help to combat lifestyle diseases. This is aligned with the Indigenous understanding of 'holistic wellness, including the spiritual, physical, mental and emotional spheres' (109).

Need to further enhance culturally aligned healthcare

To further advance culturally aligned healthcare services, programs need to continue to integrate 'culturally safe interventions' (109, 110). This becomes even more relevant when it is recommended that these culturally safe interventions be applied in chronic disease prevention among urban Indigenous People due to the morbidity, multimorbidity and mortality rates in Indigenous Communities being significantly higher than their counterparts (109, 110). Relating to the ability for practitioners to be culturally safe, the implementation of a program composed of a toolkit for the student practitioners and the clinicians could act as a

useful strategy to enhance culturally aligned healthcare services (109). Understanding culture for Indigenous people as an interactive process will allow and better equip student practitioners to focus on patients priorities, and deliver healthcare that promotes collaboration and self-determination (109).

Need for greater reach and wider impact

Participants expressed the need to enhance the healthcare service to reach more people in the Community. For this to come to fruition, the HoHA—AHAH would need further government financial support to upgrade equipment, refurnish the clinical space, add more healthcare services, expand the sessions and times in which services are offered, recruit more student practitioners and clinicians, provide opportunities for specialised training such as cultural safety programs, create a facility for child-minding to promote Indigenous women to seek care as well as advertise within Aboriginal Community Controlled Health Organisations to collaborate and reach a wider Community. Actively collaborating with Aboriginal Community Controlled Health Organisations will improve trust and access and therefore reach a wider community among Aboriginal people as these organisations provide culturally safe, respectful and appropriate healthcare that has continued to improve access to healthcare for Indigenous people here in Australia (110). This will in return uphold the self-determination principles HoHA model of healthcare delivery has in Thornbury, Melbourne.

This study presents a qualitative evaluation of the HoHA—AHAH model and the results are based on the perspectives of the recipients of the health services. This is a potential limitation of the study as it is unknown whether the attitudes of other Community members, who did not participate in the study, would differ from the findings presented here.

Conclusion

Whilst it is essential to focus on strategies to close the health gap between Aboriginal and non-Aboriginal people, ensuring Aboriginal Communities have unimpeded access to diverse health care services that demonstrate effectiveness, cost-effectiveness, cultural safety and sensitivity should also be a priority for policy makers at all levels of government. HoHA—AHAH demonstrates that this model value-adds to existing approaches to increase accessibility to allied and complementary healthcare services and offers a framework that may help to close the health Gap between Aboriginal and non-Aboriginal people here in Australia.

CHAPTER 6: REFLECTIONS, DISCUSSION & CONCLUSION

Reflections

Qualitative, Indigenist health research is not only a complex type of research to undertake but also requires a deeper understanding on how to conduct research with and for Indigenous people rather than at and about Indigenous people (30, 81, 111, 112). This involves actioning reconciliation through research.

Reconciliation (allied research paradigm)

Reconciliation is about coming to terms with what has happened in the past in a manner that helps to overcome conflict and establishes respectful, inclusive, and healthy relationships among Indigenous and non-Indigenous people (113). Reconciliation is necessarily tied to Indigenous land rights, sovereignty and preservation of languages and culture (113).

This begins with studying Indigenous scholars' and authors` work and starting to understand what it means to establish respectful relationships. For this project, this meant to build respectful relationships slowly and organically by attending the Fitzroy Stars Football and Netball Club at the Croxton Hall where the local Community came for their allied health treatments such as chiropractic services. Building respectful and healthy relationships started with the administrators of the program. This included online meetings when COVID-19 restrictions limited our movement as well as coming together and forming many yarning circles with the administrators at the Croxton Hall. Once the administrators felt safe and comfortable for this project to progress, they were able to provide me the space to attend the Croxton Hall and observe the Community members receiving healthcare services such as chiropractic. These allowed members of the community to meet me and build trust by

socially yarning in their safe space. The open plan setting allowed the Community to meet in what is known as the ‘gathering space’ and receive chiropractic services as well as socially yarn with each other during their treatment. This environment is culturally safe and appropriate, meeting the needs of the Community. It was within this space that I was able to connect with the Community and seek permission for anyone that wanted to participate in this project. Although this is the most culturally appropriate way of recruiting Indigenous participants it is also one of the most challenging ways to recruit participants in a study with time constraints. This is because I was only able to attend the clinic once a week as chiropractic services were only offered on the Tuesday afternoons. There were also many weeks where we were unable to attend the clinic due to what is known as ‘sorry business’, which are days of mourning when most Community activities shut down to respectfully pay tribute to the life of a deceased member of the Community . The Indigenous Community has a high incidence of mortality which was quite evident due to the amount of ‘sorry business’ that this local Community experienced in such a short period of time. ‘Sorry businesses include a Community-wide funeral service. Grief fatigue was also a phenomenon often described by Elders and members of the Community which impacted on their returning to the Fitzroy Stars Football and Netball Club due to the amount of people who had passed away in their community.

How can we all work towards reconciliation?

In health research, reconciliation includes understanding the negative health impacts of colonisation along with a commitment to reviewing and refining the colonial structures that continue to fuel health inequities. Pathways for reconciliation for health researchers should aim to better understand how health research itself continues to threaten Indigenous populations through deficit-based approaches to Indigenous health. This deficit-based

approach means traditionally benefited researchers and the knowledge base of the dominant groups rather than Indigenous Communities. To work towards reconciliation is to maintain and build upon the principle's behind self-determination for Indigenous people. Liberation for Indigenous people is the defining goal of Indigenist research, by creating research that promotes self-determination for Indigenous people and Communities that can be respectfully translated and used to support and further legitimise Aboriginal epistemologies, axiologies, and ontologies. The HoHA clinic and its models provides evidence of self-determination through its design and practice by supporting Indigenist research as well as demonstrating the efficacy of this in the translation of positive impacts on the Community who were involved in the research project. Both the clinic design and the use of yarning to evaluate the effectiveness, promoted self-determination of participants through Community-informed research findings that can enhance the clinic for the Community. Hands on Health Australia and its program Aboriginal Health in Aboriginal Hands aligned with the principles of Indigenist research (28). To answer the question on how 'all' Australians can work towards reconciliation, the treaty for Victoria could be the answer, as it is stated that the 'pragmatic necessity for post-colonial reconciliation' would be to have a treaty (114). This is stated to be the 'embodiment of Aboriginal self-determination' (115).

This study attempted to make its research findings and recommendations, translatable, and useful, aligning with self-determination principles and Indigenist research methodologies for both the Community and the HoHA—AHAH program to enhance the access to healthcare for Indigenous people here in Melbourne. This was done by working closely with the AHAH coordinator and communicating the findings of the yarns as soon as the themes emerged to better induct new students coming into the program to care for Indigenous members of the Community. Reconciliation respects and fosters Indigenous self-determination in healthcare

and health research. Honour and respect Indigenous perspectives, identify our positionality and learn and listen to the Indigenous ways of knowing, being and doing.

Discussions

Indigenous Australians continue to suffer from the effects of colonisation despite the vast amount of research published in this area as well as the efforts government and community health organisations have made to help curb the health gap between Indigenous and non-Indigenous Australians (45, 49, 54, 57, 116). The national agreement report proposed by the Australian government to Close the Gap in life expectancy within a generation by 2031, states that one of the drivers of the gap in life expectancy includes the 'rates of accessing/utilisation of health services' (117). According to the latest update pertaining to the goals for the Aboriginal and Torres Strait Islander Health plan 2013-2023 published in December of 2021, Indigenous-specific health checks for all age groups are not on track (117). Compounding this concerning trajectory is the rate of Indigenous-specific health checks by state and territory between 2020-2021 for which Victoria has the poorest record (117).

The implementation plan has set a total of twenty goals aimed to be achieved by 2023, highlighting the importance of prevention and early intervention healthcare as a focal point to help the Australian Government Closing the Gap targets set in the National Indigenous Reform Agreement in 2008-09 (117). Out of the twenty goals, six are not on track and three have not been assessed due to the COVID-19 impact on healthcare services (117). Goals that are not on track and could not be assessed include; smoking during pregnancy; HbA1c checks for people with type 2 diabetes; Indigenous specific health checks from ages zero to over

fifty-five years; blood pressure tests for people with type 2 diabetes and renal function tests for people with type 2 diabetes (117).

With growing pressures on the healthcare system and Medicare such as increases in costs, delays in treatments, the push towards removing bulk billing services and increasing fee-for-service healthcare, the ability for these goals to be achieved will require coordinated multidisciplinary care across a wide range of health service delivery to co-manage these modifiable lifestyle diseases and chronic illnesses in an aging population (47, 53, 58, 118-120). Also a larger emphasis must be placed on tackling Indigenous youth healthcare to prevent the development of chronic diseases associated with modifiable lifestyle factors as it is in this age group that we see a noticeable gap in addressing healthcare (121). By targeting youth healthcare, it is more likely to enable prevention of chronic diseases before they become mature adults, as well as establishing life-long healthcare practises that encompasses wholistic care that is culturally safe and well-received by Indigenous youth.

Aboriginal Community Controlled Health Organisations have been providing services for Indigenous Australians with the expertise and the right to self-determination by Indigenous people in Australia to support Closing the Gap since first established in Redfern in 1971 (117, 122). However, when looking at the proportion of Indigenous-specific health checks for Aboriginal Australians by type of service provider in Victoria, a higher proportion of Indigenous people have utilised non-Aboriginal community controlled health organisation over the community controlled sector (117). With the recent finding that Victoria is falling behind on: reaching targets pertaining to access to health services; as well as fewer Indigenous people in Victoria utilising community controlled sectors (compared to Indigenous people in other states and territories in Australia), the Victorian government has a

responsibility to re-evaluate plans to bring this target back on track to help achieve Closing of the health Gap between Indigenous people and their counterparts (117).

In Chapters one and two, the not-for-profit organisation, Hands on Health Australia (HoHA) and its program Aboriginal Health in Aboriginal Hands (AHAH) was introduced, which delivers allied and complementary healthcare services to Indigenous and non-Indigenous people in Thornbury, Melbourne, Victoria (31). The theoretical framework underpinning this program is in keeping with the preconditions required to achieve access to healthcare for Indigenous people. To fulfill the conditions required to promote access to healthcare, organisations should consider the five dimensions of accessibility to healthcare as well as implementing the 6L's principles, described by Uncle Paul Callaghan and Paul Gordon (73, 74).

The findings of the yarning studies identified the strengths of the program from both the developers' perspective as well as the recipients of the program.

Table 7. Strengths of the AHAH program perceived by both the developers and recipients

Perceptions from the developers of the program	**Perceptions from the recipients of the program**
Unique, holistic clinic highlighting socially inclusive care	Accessible and affordable healthcare clinic
Culturally aware and appropriate healthcare clinic	Culturally appropriate healthcare clinic
Enhances employment opportunities	Wellness healthcare

The table below presents the limitations of the program from both the perspective of developers and recipients of the program.

Table 8. Limitations of the AHAH program perceived by both the developers and recipients

Perceptions from the developers of the program	**Perceptions from the recipients of the program**
Need further reach and wider impact	Need for greater reach and wider impact
Communication barriers	Need to further enhance culturally aligned healthcare

According to the results arising from chapters four and five, as described by the developers and the recipients of the Aboriginal Health in Aboriginal Hands program, the perceived successes of the program were consistent with conditions and recommendations arising from the five dimensions of accessibility to healthcare and the 6Ls Indigenous principles of engaging with Indigenous Communities. These strengths are valuable when considering that this location is based at an Indigenous Community sporting club supporting youth participating in football and netball. It is this location that improves the reach of healthcare for younger Indigenous people in this inner-city area of Melbourne, to help address the health gap in this age group (121). However, the limitations raised by both groups warrant further consideration to potentially improve the program and further enhance Community access to culturally aligned healthcare based upon the 6Ls Indigenous principles of engaging with Indigenous Communities. As this organisation is not-for-profit, to help address the program`s perceived limitations, tertiary and government institutions must continue to support this and similar organisations and work collaboratively by regularly engaging with the developers and

end-users of the program to ensure improved access to healthcare for Indigenous people in Victoria.

Strengths of the study

This study implemented Indigenous methodologies using qualitative data to capture richly textured information pertaining to the specific areas of research interest. The strengths and limitations of the AHAH program emerged by interviewing the people who use these health services and those who helped develop the services.

Limitations of the study

The small sample size in each group, investigating only one location in Melbourne, the time constraints both due to the master's program as well as COVID-19 pandemic impacts do not allow the findings reported in this study to be generalisable.

Recommendations for future research

Further Indigenous health research using Indigenous methodologies to identify the strengths and limitations of all the Hands on Health Australia services around Australia will complement the findings and recommendations arising from this study. To better understand and appreciate what this organisation brings to Communities most in need, as well as the perspectives of healthcare practitioners who help deliver these services. These learnings will provide deeper insights into how this and similar organisations value-add to the delivery of culturally sensitive, accessible, and affordable healthcare for Indigenous Communities.

Conclusion

Hands on Health Australia and its program Aboriginal Health in Aboriginal Hands have been very well received by members of the Community who use these services. The findings arising from this research provide valuable insights into how this program and its health services could be strengthened and expanded to continue offering healthcare that is both culturally aligned and accessible to members of the Aboriginal Community. The impact of COVID-19 and isolation requirements that have occurred in Melbourne, Australia will have almost certainly exacerbated the aforementioned issues of access to healthcare. So it is imperative research and healthcare organisations continue to work towards closing the health gap between Indigenous people and their counter-parts by delivering not only 'universal' Medicare and ACCHO health services but also cross-cultural health organisations such as Hands on Health Australia, as this model has illustrated how it can value-add to the already established health services for Indigenous people in Australia.

References

1. Welfare AIoHa. Indigenous Australians 2022 [updated 19/08/2022. Available from: https://www.aihw.gov.au/reports-data/population-groups/indigenous-australians/overview.
2. Gracey MP, King MP. Indigenous health part 1: determinants and disease patterns. The Lancet (British edition). 2009;374(9683):65-75.
3. Carson B, Dunbar T, Chenhall RD, Bailie R. Social Determinants of Indigenous Health. Sydney: Taylor & Francis Group; 2007.
4. Commission AHR. Indigenous peoples in Australia – a human rights based approach 2007 [Available from: https://humanrights.gov.au/about/news/speeches/social-determinants-and-health-indigenous-peoples-australia-human-rights-based.
5. Raeburn T, Sale K, Saunders P, Doyle AK. Aboriginal Australian mental health during the first 100 years of colonization, 1788–1888: a historical review of nineteenth-century documents. History of psychiatry. 2022;33(1):3-20.
6. Vindigni D. Promoting the musculoskeletal health of Indigenous Australians living in rural Communities. Aboriginal Health in Aboriginal Hands: University of Newcastle; 2005.
7. AIHW. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples: 2015 2015 [updated 27/04/2022. Available from: https://www.aihw.gov.au/reports/indigenous-health-welfare/indigenous-health-welfare-2015/contents/table-of-contents.
8. McMahon SK, Haynes A, Ratnam N, Grant MT, Carne CL, Jones TW, et al. Increase in type 2 diabetes in children and adolescents in Western Australia. Medical Journal of Australia. 2004;180(9):459-61.
9. Healthinfonet AI, Thomson N, Macrae A. Overview of Australian Indigenous health status 2012. 2014.
10. Northern and Indigenous Health and Health Care: University of Saskatchewan; 2018.
11. Commission AHR. Rights to self determination. 2011.
12. Day A, Francisco A. Social and emotional wellbeing in Indigenous Australians: identifying promising interventions. Australian and New Zealand journal of public health. 2013;37(4):350-5.
13. Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS). AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research. 2020.
14. Deficit Discourse and Strengths-based Approaches: Changing the Narrative of Aboriginal and Torres Strait Islander Health and Wellbeing: Lowitja Institute; 2018.
15. Harfield SG, Davy C, McArthur A, Munn Z, Brown A, Brown N. Characteristics of Indigenous primary health care service delivery models: a systematic scoping review. Globalization and health. 2018;14(1):1-11.
16. Sherwood JM. Do no harm: decolonising Aboriginal health research. University of New South Wales. Social Sciences & International Studies; 2010.
17. Adelson N. The Embodiment of Inequity: Health Disparities in Aboriginal Canada. Canadian journal of public health. 2005;96(S2):S45-S61.
18. Sherwood J. Colonisation - It's bad for your health: The context of Aboriginal health. Contemporary nurse : a journal for the Australian nursing profession. 2013;46(1):28-40.
19. Commission P. Overcoming Indigenous Disadvantage-Key Indicators 2016 Report. 2016.
20. Waterworth P, Pescud M, Braham R, Dimmock J, Rosenberg M. Factors Influencing the Health Behaviour of Indigenous Australians: Perspectives from Support People. PloS one. 2015;10(11):e0142323-e.

21. Loutfi D, Law S, McCutcheon C, Carlin R, Torrie J, Macdonald ME. Health Planning for Indigenous Populations: A Rapid Evidence Review. International indigenous policy journal. 2018;9(1).
22. Priest N, Mackean T, Davis E, Briggs L, Waters E. Aboriginal perspectives of child health and wellbeing in an urban setting: Developing a conceptual framework. Health Sociology Review. 2012;21(2):180-95.
23. Coldwell I. Killing the mockingbird: Systems failure and a radical hope for re-grounding responsibility and access to health care in a Mallee town community. Rural Society. 2010;20(1):35-50.
24. Opie C, Gibson-Thorpe B, Lees C, Haines H. 'Believe in me and I will believe in myself', a rural Australian health service learns how to mangan dunguludja ngatan (build strong employment) for Aboriginal and Torres Strait Islander people: a qualitative study. Human Resources for Health. 2019;17(1):1-14.
25. Kim Elston J, Saunders V, Hayes B, Bainbridge R, McCoy B. Building indigenous Australian research capacity. Contemporary Nurse. 2013;46(1):6-12.
26. Rae K, Weatherall L, Hollebone K, Apen K, McLean M, Blackwell C, et al. Developing research in partnership with Aboriginal communities–strategies for improving recruitment and retention. Rural and Remote Health. 2013;13(2):1-8.
27. Vicary D, Bishop B. Western psychotherapeutic practice: Engaging Aboriginal people in culturally appropriate and respectful ways. Australian Psychologist. 2005;40(1):8-19.
28. Rigney L-I. Internationalization of an Indigenous Anticolonial Cultural Critique of Research Methodologies: A Guide to Indigenist Research Methodology and Its Principles. Wicazo sa review. 1999;14(2):109-21.
29. Wilson S. What is indigenous research methodology? Canadian journal of native education. 2001;25(2):175.
30. Wilson S. Guest Editorial: What is an Indigenist Research Paradigm? Canadian journal of native education. 2007;30(2):193.
31. Health Ho. Hands on Health-About us https://hoha.org.au/about-us/2022 [
32. Taylor J, Dollard J, Weetra C, Wilkinson D. Contemporary management issues for aboriginal community controlled health services. Australian Health Review. 2001;24(3):125-32.
33. Davy C, Harfield S, McArthur A, Munn Z, Brown A. Access to primary health care services for Indigenous peoples: A framework synthesis. Int J Equity Health. 2016;15(1):1-9.
34. Kingsley J, Munro-Harrison E, Jenkins A, Thorpe A. "Here we are part of a living culture": Understanding the cultural determinants of health in Aboriginal gathering places in Victoria, Australia. Health & place. 2018;54:210-20.
35. Hayman NE, Askew DA, Spurling GK. From vision to reality: a centre of excellence for Aboriginal and Torres Strait Islander primary health care. Med J Aust. 2014;200(11):623-4.
36. Durey A, McEvoy S, Swift-Otero V, Taylor K, Katzenellenbogen J, Bessarab D. Improving healthcare for Aboriginal Australians through effective engagement between community and health services. BMC health services research. 2016;16(1):224-.
37. Ermine W, Sinclair R, Browne M. Kwayask itôtamowin: Indigenous research ethics: Indigenous Peoples' Health Research Centre; 2005.
38. Bessarab D, Ng'andu B. Yarning About Yarning as a Legitimate Method in Indigenous Research. International Journal of Critical Indigenous Studies. 2010;3(1):37-50.
39. Vindigni DR, Polus BI, Edgecombe G, Howard M, van Rotterdam J, Redpath F, et al. The STTEP: a Model for musculoskeletal health care in marginalized communities. The journal of alternative and complementary medicine (New York, NY). 2009;15(8):885-90.

40. Vindigni D, Polus B, van Rotterdam J, da Costa C, Edgecombe G, Walsh M, et al. The sustainable training, treatment, employment program model: Effects of manual therapy on musculoskeletal pain and limitation in a Filipino squatter community. Journal of Manipulative and Physiological Therapeutics. 2011;34(6):381-7.
41. Hoare T, Levy C, Robinson MP. Participatory action research in Native communities: Cultural opportunities and legal implications. The Canadian Journal of Native Studies. 1993;13(1):43-68.
42. Miller A, Massey PD, Judd J, Kelly J, Durrhein D, Clough AR, et al. Using a participatory action research framework to listen to Aboriginal and Torres Strait Islander people in Australia about pandemic influenza. Rural and remote health. 2015;15(3):[188]-[97].
43. Brands J, Gooda M. Putting the users of research in the driver's seat: the Cooperative research centre for Aboriginal Health's new approach to research development. Australian Aboriginal Studies. 2006(2):27-35.
44. University R. Dhumbah Goorowa Reconciliation Plan 2019-2020. 2019.
45. Bond CJ, Singh D. More than a refresh required for closing the gap of Indigenous health inequality. Medical journal of Australia. 2020;212(5):198-9.e1.
46. Smith LT. Decolonizing Methodologies: Research and Indigenous Peoples. London: Bloomsbury Academic & Professional; 2021.
47. Boxall A-M, Gillespie J. Making Medicare: The Politics of Universal Health Care in Australia. Sydney: UNSW Press; 2013.
48. Moore E, Lawn S, Oster C, Morello A. Self-management programs for Aboriginal and Torres Strait Islander Peoples with chronic conditions: A rapid review. Chronic Illness. 2019;15(2):83-123.
49. Durey A, Thompson SC. Reducing the health disparities of Indigenous Australians: Time to change focus. BMC health services research. 2012;12(1):151-.
50. Diaz A, Sverdlov AL, Kelly B, Ngo DT, Bates N, Garvey G. Nexus of Cancer and cardiovascular disease for Australia's First Peoples. JCO global oncology. 2020;6.
51. Lin IB, Bunzli S, Mak DB, Green C, Goucke R, Coffin J, et al. Unmet Needs of Aboriginal Australians With Musculoskeletal Pain: A Mixed-Method Systematic Review. Arthritis care & research (2010). 2018;70(9):1335-47.
52. Lin IB, O'Sullivan PB, Coffin JA, Mak DB, Toussaint S, Straker LM. 'I am absolutely shattered': the impact of chronic low back pain on Australian Aboriginal people. Eur J Pain. 2012;16(9):1331-41.
53. Callander EJ, Fox H, Lindsay D. Out-of-pocket healthcare expenditure in Australia: trends, inequalities and the impact on household living standards in a high-income country with a universal health care system. Health economics review. 2019;9(1):1-8.
54. Couzos S, Delaney Thiele D. The International Covenant on Economic, Social and Cultural Rights and the right to health: is Australia meeting its obligations to Aboriginal peoples? Medical journal of Australia. 2007;186(10):522-4.
55. Hayman NE, White NE, Spurling GK. Improving Indigenous patients' access to mainstream health services: the Inala experience. Medical journal of Australia. 2009;190(10):604-6.
56. Korda RJ, Banks E, Clements MS, Young AF. Is inequity undermining Australia's universal health care system Socio-economic inequalities in the use of specialist medical and non-medical ambulatory health care. Australian and New Zealand journal of public health. 2009;33(5):458-65.
57. Azzopardi P, Blow N, Purcell T, Brown N, Ritchie T, Brown A. Investing in the health of Aboriginal and Torres Strait Islander adolescents: a foundation for achieving health equity. Medical Journal of Australia. 2020;212(5):202-4. e1.

58. Nolan-Isles D, Macniven R, Hunter K, Gwynn J, Lincoln M, Moir R, et al. Enablers and Barriers to Accessing Healthcare Services for Aboriginal People in New South Wales, Australia. International journal of environmental research and public health. 2021;18(6):3014.
59. Nolan-Isles D, Macniven R, Hunter K, Gwynn J, Lincoln M, Moir R, et al. Enablers and Barriers to Accessing Healthcare Services for Aboriginal People in New South Wales, Australia. International Journal of Environmental Research and Public Health. 2021;18(6):3014.
60. Znidarsic J, Kirksey KN, Dombrowski SM, Tang A, Lopez R, Blonsky H, et al. "Living Well with Chronic Pain": Integrative Pain Management via Shared Medical Appointments. Pain Medicine. 2021;22(1):181-90.
61. Freeman T, Baum F, Lawless A, Labonté R, Sanders D, Boffa J, et al. Case Study of an Aboriginal Community-Controlled Health Service in Australia: Universal, Rights-Based, Publicly Funded Comprehensive Primary Health Care in Action. Health and human rights. 2016;18(2):93-108.
62. Milligan E, West R, Saunders V, Bialocerkowski A, Creedy D, Minniss FR, et al. Achieving cultural safety for Australia's First Peoples: a review of the Australian Health Practitioner Regulation Agency-registered health practitioners' Codes of Conduct and Codes of Ethics. Australian Health Review. 2021.
63. Blanchette M-A, Stochkendahl MJ, Borges Da Silva R, Boruff J, Harrison P, Bussières A. Effectiveness and economic evaluation of chiropractic care for the treatment of low back pain: a systematic review of pragmatic studies. PLoS One. 2016;11(8):e0160037.
64. Yeganeh M, Baradaran HR, Qorbani M, Moradi Y, Dastgiri S. The effectiveness of acupuncture, acupressure and chiropractic interventions on treatment of chronic nonspecific low back pain in Iran: A systematic review and meta-analysis. Complementary therapies in clinical practice. 2017;27:11-8.
65. Tao WW, Jiang H, Tao XM, Jiang P, Sha LY, Sun XC. Effects of Acupuncture, Tuina, Tai Chi, Qigong, and Traditional Chinese Medicine Five-Element Music Therapy on Symptom Management and Quality of Life for Cancer Patients: A Meta-Analysis. J Pain Symptom Manage. 2016;51(4):728-47.
66. Saracutu M, Rance J, Davies H, Edwards DJ. The effects of osteopathic treatment on psychosocial factors in people with persistent pain: A systematic review. International Journal of Osteopathic Medicine. 2018;27:23-33.
67. Coulter ID, Crawford C, Vernon H, Hurwitz EL, Khorsan R, Booth MS, et al. Manipulation and mobilization for treating chronic nonspecific neck pain: a systematic review and meta-analysis for an appropriateness panel. Pain physician. 2019;22(2):E55.
68. Arienti C, Bosisio T, Ratti S, Miglioli R, Negrini S. Osteopathic manipulative treatment effect on pain relief and quality of life in oncology geriatric patients: a nonrandomized controlled clinical trial. Integrative cancer therapies. 2018;17(4):1163-71.
69. Furlan AD, Brosseau L, Imamura M, Irvin E. Massage for low-back pain: a systematic review within the framework of the Cochrane Collaboration Back Review Group. Spine. 2002;27(17):1896-910.
70. Baker K, McDonald J, Steel A. Tackling health inequity: a commentary on the potential of acupuncture to improve health outcomes of marginalised populations. Acupuncture in medicine : journal of the British Medical Acupuncture Society. 2021;39(5):533-7.
71. Crawford C, Boyd C, Paat CF, Price A, Xenakis L, Yang E, et al. The impact of massage therapy on function in pain populations—A systematic review and meta-analysis of randomized controlled trials: Part I, patients experiencing pain in the general population. Pain Medicine. 2016;17(7):1353-75.

72. Moher D, Liberati A, Tetzlaff J, Altman DG. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. Int J Surg. 2010;8(5):336-41.
73. Levesque J-F, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. Int J Equity Health. 2013;12:18-.
74. Paul Callaghan PG. iridescence Finding your colours and living you story: MoshPit Publishing; 2016.
75. Vaismoradi M, Turunen H, Bondas T. Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. Nursing & health sciences. 2013;15(3):398-405.
76. Laycock A. Researching indigenous health : a practical guide for researchers. Carlton South, Vic: Lowitja Institute; 2011.
77. Harri A, Erdem C, Coble KH, Knight TO. Crop yield distributions: A reconciliation of previous research and statistical tests for normality. Review of Agricultural Economics. 2009;31(1):163-82.
78. Jaworsky D. An allied research paradigm for epidemiology research with Indigenous peoples. Archives of Public Health. 2019;77(1):1-12.
79. Hammarberg K, Kirkman M, de Lacey S. Qualitative research methods: when to use them and how to judge them. Human Reproduction. 2016;31(3):498-501.
80. Malterud K. Qualitative Metasynthesis : A Research Method for Medicine and Health Sciences. Milton, UNITED KINGDOM: Taylor & Francis Group; 2019.
81. Roman C. Indigenous people and qualitative research - making it work. Aboriginal and islander health worker journal. 2016;40:11-6.
82. Mertova P, Webster L. Using Narrative Inquiry As a Research Method : An Introduction to Critical Event Narrative Analysis in Research, Teaching and Professional Practice. Milton, UNITED KINGDOM: Taylor & Francis Group; 2019.
83. Babbie ER. The basics of social research / [eReserve]. Belmont, CA: Wadsworth, Cengage Learning; 2014.
84. Jamshed S. Qualitative research method-interviewing and observation. Journal of basic and clinical pharmacy. 2014;5(4):87-8.
85. Lindlof TR, Taylor BC. Qualitative communication research methods. 3rd ed. ed. Thousand Oaks, Calif: SAGE; 2011.
86. Walker M, Fredericks B, Mills K, Anderson D. "Yarning" as a Method for Community-Based Health Research With Indigenous Women: The Indigenous Women's Wellness Research Program. Health care for women international. 2014;35(10):1216-26.
87. MacNiven R, Coombes J, Wilson R, Simon A, MacKean T, Hunter K, et al. Understanding implementation factors and participant experiences of a cluster randomised controlled trial to prevent falls among older Aboriginal people: A process evaluation protocol. Injury Prevention. 2021.
88. Bryant L. Critical and creative research methodologies in social work. London, [England] ;: Routledge; 2016.
89. Byrne A-L, McLellan S, Willis E, Curnow V, Harvey C, Brown J, et al. Yarning as an Interview Method for Non-Indigenous Clinicians and Health Researchers. Qualitative health research. 2021:1049732321995802-.
90. Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, Hoagwood K. Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. Adm Policy Ment Health. 2015;42(5):533-44.
91. Vasileiou K, Barnett J, Thorpe S, Young T. Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. BMC Medical Research Methodology. 2018;18(1):148.

92. Benoot C, Hannes K, Bilsen J. The use of purposeful sampling in a qualitative evidence synthesis: A worked example on sexual adjustment to a cancer trajectory. BMC Medical Research Methodology. 2016;16(1):21.
93. Guest G, Namey E, Chen M. A simple method to assess and report thematic saturation in qualitative research. PLOS ONE. 2020;15(5):e0232076.
94. Galvin R. How many interviews are enough? Do qualitative interviews in building energy consumption research produce reliable knowledge? Journal of Building Engineering. 2015;1:2-12.
95. Nowell LS, Norris JM, White DE, Moules NJ. Thematic Analysis: Striving to Meet the Trustworthiness Criteria. International Journal of Qualitative Methods. 2017;16(1):1609406917733847.
96. Zamawe FC. The Implication of Using NVivo Software in Qualitative Data Analysis: Evidence-Based Reflections. Malawi medical journal. 2015;27(1):13-5.
97. Health AIo, Welfare. Cultural safety in health care for Indigenous Australians: monitoring framework. Canberra: AIHW; 2022.
98. Wettasinghe PM, Allan W, Garvey G, Timbery A, Hoskins S, Veinovic M, et al. Older Aboriginal Australians' health concerns and preferences for healthy ageing programs. International journal of environmental research and public health. 2020;17(20):7390.
99. Russell LM. Reports indicate that changes are needed to close the gap for Indigenous health. Medical journal of Australia. 2013;199(11):737-8.
100. Mitrou F, Cooke M, Lawrence D, Povah D, Mobilia E, Guimond E, et al. Gaps in Indigenous disadvantage not closing: a census cohort study of social determinants of health in Australia, Canada, and New Zealand from 1981-2006. BMC public health. 2014;14(1):201-.
101. Fortuna KL, Brusilovskiy E, Snethen G, Brooks JM, Townley G, Salzer MS. Loneliness and its association with physical health conditions and psychiatric hospitalizations in people with serious mental illness. Social work in mental health. 2020;18(5):571-85.
102. Hayman N. Strategies to improve indigenous access for urban and regional populations to health services. Heart, Lung and Circulation. 2010;19(5-6):367-71.
103. Li J-L. Cultural barriers lead to inequitable healthcare access for aboriginal Australians and Torres Strait Islanders. Chinese nursing research. 2017;4(4):207-10.
104. Welfare AIoHa. Cultural safety in health care for Indigenous Australians: monitoring framework. 2022 [updated 23/06/2022. Available from: https://www.aihw.gov.au/reports/indigenous-australians/cultural-safety-health-care-framework/contents/summary.
105. Ware V-A. Improving the accessibility of health services in urban and regional settings for Indigenous people. Canberra: AIHW; 2013.
106. Osborne K, Baum F, Brown L. What works? A review of actions addressing the social and economic determinants of Indigenous health. 2013.
107. Young C, Tong A, Gunasekera H, Sherriff S, Kalucy D, Fernando P, et al. Health professional and community perspectives on reducing barriers to accessing specialist health care in metropolitan Aboriginal communities: A semi-structured interview study. Journal of paediatrics and child health. 2017;53(3):277-82.
108. Saggers S, Gray D. Aboriginal health and society : the traditional and contemporary Aboriginal struggle for better health. North Sydney: Allen & Unwin; 1991.
109. Poitras M-E, T Vaillancourt V, Canapé A, Boudreault A, Bacon K, Hatcher S. Culturally safe interventions in primary care for the management of chronic diseases of urban Indigenous People: a scoping review. Family Medicine and Community Health. 2022;10(Suppl 1):e001606.
110. Osborn E, Ritha M, Macniven R, Agius T, Christie V, Finlayson H, et al. "No One Manages It; We Just Sign Them Up and Do It": A Whole System Analysis of Access to

Healthcare in One Remote Australian Community. International journal of environmental research and public health. 2022;19(5):2939.
111. Rigney L-I. Indigenist Research and Aboriginal Australia. 1 ed. Aldershot, England: Routledge; 2006. p. 32-48.
112. Nakata M, Nakata V, Keech S, Bolt R. Rethinking Majors in Australian Indigenous Studies. The Australian journal of indigenous education. 2014;43(1):8-20.
113. Jaworsky D. An allied research paradigm for epidemiology research with Indigenous peoples. Archives of public health = Archives belges de santé publique. 2019;77(1):22-.
114. Rigney D, Bignall S, Vivian A, Hemming S, Berg S, Bell D. Treating treaty as a technology for Indigenous nation-building. Developing governance and governing development–International case studies of Indigenous futures. 2021:119-40.
115. O'Sullivan D. Treaties and re-setting the colonial relationship: Lessons for Australia from the Treaty of Waitangi. Ethnicities. 2021;21(6):1070-92.
116. Ring IT, Griffiths K. Life expectancy for Indigenous people is improving, but closing the gap remains unacceptably slow. Medical journal of Australia. 2022;217(1):26-7.
117. Health AIo, Welfare. Tracking progress against the Implementation Plan goals for the Aboriginal and Torres Strait Islander Health Plan 2013–2023. Canberra: AIHW; 2021.
118. Bennett CC. Are we there yet?: a journey of health reform in Australia. Medical journal of Australia. 2013;199(4):251-5.
119. Faux MA. Claiming and Compliance under the Medicare Benefits Schedule: A Critical Examination of Medical Practitioner Experiences, Perceptions, Attitudes and Knowledge 2021.
120. Duckett S, Stobart A, Lin L. Not so universal: how to reduce out-of-pocket healthcare payments. 2022.
121. Brown AD, Crengle S, Tewhaiti-Smith J, Westhead S, Bingham B, Brown N, et al. The health and wellbeing of Indigenous adolescents: a global collective for an equitable and sustainable future. The Lancet. 2022;399(10322):341-3.
122. Drovandi A, Smith D, Preston R, Morris L, Page P, Swain L, et al. Enablers and barriers to non-dispensing pharmacist integration into the primary health care teams of Aboriginal community-controlled health services. Research in Social and Administrative Pharmacy. 2022;18(10):3766-74.

APPENDIX

Ethics approval letter

RMIT UNIVERSITY

Human Research Ethics Committee (HREC)
Research and Innovation office
NH&MRC Code: EC00237

Notice of Approval

Date:	**2 June 2021**
Project number:	**23249**
Project title:	***An evaluation of the factors affecting the success of an Indigenous Community based healthcare clinic at the Fitzroy Stars Football and Netball Club***
Risk classification:	**More than low risk**
Chief investigator:	**Dr Dean Vindigni**
Approval period:	From: **2 June 2021** To: **2 June 2024**

The above application has been approved by the RMIT University HREC as it meets the requirements of the *National statement on ethical conduct in human research* (NH&MRC, 2007).

Terms of approval:

1. **Responsibilities of chief investigator**
   It is the responsibility of the above chief investigator to ensure that all other investigators and staff on a project are aware of the terms of approval and to ensure that the project is conducted as approved by HREC. Approval is valid only whilst the chief investigator holds a position at RMIT University.
2. **Amendments**
   Approval must be sought from HREC to amend any aspect of a project. To apply for an amendment use the request for amendment form, which is available on the Research Ethics Platform. Amendments must not be implemented without first gaining approval from HREC.
3. **Adverse events**
   You should notify the HREC immediately (within 24 hours) of any serious or unanticipated adverse effects of the research on participants, and unforeseen events that might affect the ethical acceptability of the project.
4. **Annual reports**
   Continued approval of this project is dependent on the submission of an annual report. Annual reports must be submitted by the anniversary of approval (19 October 2022) of the project for each full year of the project.
5. **Final report**
   A final report must be provided within six months of the end of the project. HREC must be notified if the project is discontinued before the expected date of completion.
6. **Monitoring**
   Projects may be subject to an audit or any other form of monitoring by the HREC at any time.
7. **Retention and storage of data**
   The investigator is responsible for the storage and retention of original data according to the requirements of the *Australian code for the responsible conduct of research* (section 2) and relevant RMIT policies.
8. **Special conditions of approval**
   Nil.

In any future correspondence please quote the project number and project title above.

A/Prof Suzie Attiwill
Deputy Chairperson
RMIT HREC