Knowing, Being, and Doing: Aboriginal and Non-Aboriginal Collaboration in Cancer Services

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Abstract

This qualitative inquiry explored the processes and practices of collaboration as experienced by a group of Australian multidisciplinary Aboriginal and non-Aboriginal health workers. Each worker had participated, for a period of 2 to 5 years, in an Australian Government–funded project in which a range of health initiatives led to improved access to cancer services by Aboriginal communities in a rural region of South Eastern Australia. Initiatives which addressed high rates of mortality from cancer, poor access to cancer screening, and engagement with cancer treatment were developed through the formation of close working relationships between Aboriginal and non-Aboriginal health workers. These relationships were regarded as personally and professionally transformative. Through the sharing of knowledge, skills, and experiences, new ways of knowing, being, and doing emerged. Developing a deeper understanding of cross-cultural collaboration is one way of addressing complex health problems and building the capacity of the health workforce.

Keywords

Aboriginal people, Australia; cancer; community-based programs; culture / cultural competence; health and well-being; health care professionals; participatory action research (PAR); relationships, health care; research, collaborative, cross-cultural, qualitative, rural

I mean 60,000 years is a lot of years for things to happen. Then for something to come like this, how do you think they're going to understand that the white man's going to do good for them this time, you know what I mean?

—Aboriginal Elder

This powerful statement articulated by an Aboriginal Elder represents the crux of the complex health problems that Australian Aboriginal and Torres Strait Islander peoples experience in the 21st century. According to the Australian Government's annual report card (Commonwealth of Australia, 2016) on the state of Aboriginal and Torres Strait Islander health, across a range of health and well-being indicators, Australia's Indigenous peoples remain in poor health.

In the area of cancer, the disparity between the health of Aboriginal and Torres Strait Islander and non-Indigenous Australians is significant. "Between 2008 and 2012, Indigenous Australians were 1.3 times more likely to die from all cancers combined than non-Indigenous Australians" (Australian Institute of Health and Welfare [AIHW] & Australasian Association of Cancer Registries, 2014, p. 21). This is partly because Aboriginal and Torres Strait Islander peoples are more likely to be diagnosed with more advanced cancers—and particularly cancers with higher mortality rates (AIHW & Australasian Association

of Cancer Registries, 2014; Gibberd, Supramaniam, Dillon, Armstrong, & O'Connell, 2015).

The impact of colonization and racism, beliefs about cancer as a death sentence, silence about cancer in communities, a focus on other health priorities, and significant social and economic disadvantage are all factors that contribute to these levels of mortality (Durey et al., 2012; Simpson, Zubrzycki, Reid, & Jones, 2011; Treloar et al., 2013, 2014).

The existence of these serious health problems prompted a group of senior Aboriginal and non-Aboriginal health managers to apply for funding to develop new local approaches in the delivery of cancer services. The Aboriginal Health and Cancer Services—Working Together project (hereafter referred to as Working Together) was a State and Federal Government initiative, funded from 2008 to 2013,

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to address cancer-specific health outcomes for a relatively large population of Aboriginal people living in Murrumbidgee and Southern New South Wales Local Health Districts (M&SNSW LHDs), a rural region of South Eastern Australia (Simpson et al., 2011).

With a population of 479,144 situated in a large land mass of 170,095 square kilometers, approximately the size of Cambodia or Uruguay (Australian Bureau of Statistics [ABS], 2011a; Southern NSW Local Health District, 2015; World Bank, 2014), M&SNSW LHDs comprise small to medium country towns and rural properties. Demographically, the region has a relatively high proportion of Aboriginal people, 3.6%, compared with the national population of Aboriginal people, which is currently 3% of the total population (ABS, 2011b).

Prior to the Working Together project, cancer services staff and Aboriginal health staff within this health region did not actively collaborate. The project's strategy was to facilitate the development of cross-cultural working relationships to make cancer services more accessible to and utilized by Aboriginal people. Through a range of project-funded initiatives (one example of which is located in this article), Aboriginal and non-Aboriginal service providers and workers became partners in the delivery of cancer services within this region.

By 2010, the Working Together project team recognized that this strategy appeared to be generating important service delivery outcomes for the local community and transformative practices for many of the health workers. A critical opportunity emerged for the Working Together project to generate research data about cross-cultural collaboration from the health workers and community members who had, in different ways, engaged in the project-funded activities. The data collection was undertaken by the Working Together non-Aboriginal project officer and the project's non-Aboriginal research and training advisor, under the direction of an Aboriginal-led research reference group. The key research question that guided the inquiry was as follows:

Research Question 1: How do Aboriginal and non-Aboriginal health staff understand and experience cross-cultural collaboration?

The purpose was to generate evidence about how these relationships can make a difference in addressing complex health issues in order to inform policy and practice.

This article presents the results of this large qualitative inquiry. It begins with an overview of the cultural, policy, workforce, and service delivery contexts within which the research participants were located. The research methodology and Aboriginal research protocols that informed the research process are presented. An Aboriginal theoretical framework (Martin & Mirraboopa,

2003) of knowing, being, and doing informs the data analysis, with quotes from the research participants illustrating key themes. The article concludes with consideration of the contributions of the research findings to broadening and deepening our understandings of the processes, relationships, and challenges of cross-cultural collaboration.

In this article, the term *Aboriginal* will be predominantly used, as Aboriginal people are the traditional custodians of the land within M&SNSW LHDs. However, we acknowledge that there are Torres Strait Islander people living in M&SNSW LHDs.

Cultural Context

In the Australian context, recognizing the fundamental influence of Aboriginal culture on health outcomes is one of the critical dimensions in both understanding and responding to the intransigent nature of current health disparities. The Aboriginal and Torres Strait Islander approach to health is less about diseases and specific parts of the body, and more about relationships, family, and community (Sherwood & Edwards, 2006). Factors relating to culture, social connections, racism, communication, personal choice, and distrust of health service providers influence Aboriginal and Torres Strait Islander peoples' health behaviors (Waterworth, Dimmock, Pescud, Braham, & Rosenberg, 2016).

Shahid and Thompson (2009), in particular, examine beliefs about cancer in Indigenous people from Australia, Canada, and New Zealand. They state that effective approaches to health and well-being need to include the physical, mental, emotional, and spiritual as well as the "concept that individual, family and community are inseparable" (Shahid & Thompson, 2009, p. 109). There is growing recognition that cancer services need to be delivered in a culturally safe, sensitive, and supportive environment, where there is "no assault, challenge or denial of their identity, of who they are and what they need" (Williams, 1999, p. 213). According to this perspective, Indigenous health outcomes will only change when Aboriginal knowledge, voices, and opinions are allowed to inform policy, research, and service delivery for Aboriginal people (Sherwood & Edwards, 2006).

However, while these principles have been clearly articulated, putting theory into practice is complex and challenging. For example, in the provision of cancer services, the examination and understanding of cultural difference often creates discomfort for health professionals and opportunities to facilitate talk about difference to "promote a more inclusive culture in cancer care is needed" (Newman et al., 2013, p. 445). While health disparities between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians are well known,

effective evidence-based strategies that address the impact of racism, colonization, and social and economic disadvantage remain lacking.

The Policy Context

Since 2007, the Council of Australian Governments (COAG) has set targets to close the gap between Aboriginal and Torres Strait Islander health outcomes and the health outcomes of the broader population, with the establishment of Aboriginal Reform National Partnership Agreements (Taylor & Thompson, 2011). At a state level, these imperatives are reflected in policy documents such as the *NSW State Health Plan: Towards 2021* (New South Wales [NSW] Government, 2014), which focuses on an articulation and implementation of Aboriginal health initiatives that are informed by core values of collaboration, respect, openness, and empowerment. Other policies, such as the *NSW Aboriginal Health Plan 2013–2023* (NSW Government, 2012), establish mandatory directives for staff with an emphasis on the need "to build respectful, trusting and effective partnerships between NSW Health and the Aboriginal communities" (p. 4). These policy documents do not, however, define collaboration or partnerships; rather, they appear to assume that health staff will have a shared understanding of how "trusting and collaborative working relationships" (NSW Government, 2012, p. 10) are created.

Workforce and Service Delivery Contexts

Closing the gap in Indigenous health outcomes places certain levels of responsibility and expectations on the Aboriginal and non-Aboriginal health workforce. The historical legacies of colonization continue to challenge Aboriginal and non-Aboriginal health service providers and practitioners. Low levels of trust and confidence, and, in some areas, a lack of collaborative working relationships between Aboriginal and non-Aboriginal health workers and services are not uncommon (Taylor, Bessarab, Hunter, & Thompson, 2013). A contributing factor is that the non-Aboriginal health workforce often lacks the skills, knowledge, values, and confidence to address the health needs of the Aboriginal community in ways that are culturally responsive, respectful, and safe.

Non-Indigenous health workers also regard the development of sustainable, collaborative working relationships with Aboriginal colleagues and services as challenging, daunting, and complex (Bennett, Zubrzycki, & Bacon, 2011; Wilson, Magarey, Jones, O'Donnell, & Kelly, 2015). However, as Rawsthorne (2014) argues in her research in the area of domestic violence, welfare workers do not have to be Aboriginal to be able to form

trusting relationships with Aboriginal people, but they do need to make a commitment to take the time needed to build trusting relationships. This perspective is further reinforced by Herring, Spangaro, Lauw, and McNamara (2013) who assert that addressing these service delivery and workforce issues requires a commitment by service providers to become informed, take a stance, and reach out to the local Aboriginal community.

Collaboration Literature

According to Keast and Madell (2013), collaboration between social services reduces overlap and duplication, increases organizational legitimacy, and facilitates the resolution of intractable social problems. There is also broad understanding that human service collaborations are based on relationships (Bovaird, 2006). However, Cheek (2008) is wary about making assumptions that collaboration is going to be beneficial and that everyone knows what it is. She argues that collaboration requires that all parties think through what is open to compromise and what is nonnegotiable; but what there has to be, "without question, is patience, hesitation and deep thinking" (Cheek, 2008, p. 1602).

Cross-cultural collaborative relationships or partnerships between Aboriginal and Torres Strait Islander and non-Indigenous services and workers are regarded as particularly critical in facilitating community engagement and breaking down barriers to service delivery (Blignault, Haswell, & Jackson-Pulver, 2015). While such partnerships can improve the cultural appropriateness of health services, "the legacy of Australia's history, continuing Aboriginal health disparities and different ways of working can also cause these partnerships to be difficult and sometimes tenuous" (Taylor et al., 2013, p. 2).

Aigner et al. (2014) recognize collaboration between Aboriginal and non-Aboriginal Australians as a complex, precarious space navigated only with courage and tenacity. They encourage a valuing of the dissenting voice and to use conflict as an opportunity to gently inquire, rather than as something to be feared and avoided. This encompasses encouraging authenticity, being genuinely and unapologetically who you are, and accepting that tension and conflict are unavoidable and provide an opportunity for growth.

These inherent complexities underscore the need to build knowledge and evidence about cross-cultural collaboration, particularly from Aboriginal health projects that have achieved successful outcomes.

An Illustration of Collaboration

Over a period of 5 years (2008–2013), the Working Together project generated a range of successful, locally

based health initiatives. These included cross-cultural awareness training, cancer awareness training, increased participation in breast screening, developing culturally appropriate cancer information, cancer camps, and the development of a DVD about men's experiences of cancer (Simpson et al., 2011). While these collaborative initiatives varied, a number of core principles were consistently applied.

During Working Together's establishment phase, key policy documents from the National Health and Medical Research Council (2003), and discussions with the Project Team which comprised an Aboriginal Elder, Aboriginal and non-Aboriginal managers, and staff from government and nongovernment organizations, informed the development of core values and protocols. These included valuing and building respectful, equal working relationships between Aboriginal and non-Aboriginal health staff; being driven from the "bottom up"; sharing community and health service consultation and control; being sustainable; and committing to a culturally sensitive process throughout (Jones, 2010; Simpson et al., 2011). These principles are reflected in the following example of a Working Together project initiative.

In 2008, BreastScreen in M&SNSW LHDs was concerned with low participation rates among eligible Aboriginal women. The Working Together project initiated discussions between senior managers in Aboriginal Health and BreastScreen NSW. The bringing together of expert knowledge from both groups led to a new strategy that prior to the mobile breast screening van going to a community, the local Aboriginal health worker would be informed and her connections with and trust from community would enable her to encourage and support Aboriginal women to attend. In addition, if an Aboriginal woman needed to be called back for further investigation and/or treatment, the Aboriginal health worker would be closely involved to counteract possible fears of mainstream health services.

The project also initiated cultural awareness training which assisted non-Aboriginal staff to understand some of the cultural factors that influenced Aboriginal women's participation in breast screening. For example if a death in the Aboriginal community had occurred just prior to or while the mobile van was there, resulting Sorry Business would almost certainly result in low or nil attendance at breast screening. Understanding the cultural context of these responses rather than nonattendance signifying a lack of interest was a critical turning point for the breast screening workers.

As a result, BreastScreen NSW (2016, Anna Cohen personal correspondence, 18th May 2016) confirms that between 2011 and 2015, a 64% increase in the biennial participation rates for 50- to 69-year-old Aboriginal women occurred across M&SNSW LHDs. Although we do not claim that this was entirely due to work undertaken by Working Together, we are confident that its contribution was significant.

The present study focuses on data generated from the Aboriginal and non-Aboriginal health workers who experienced these types of cross-cultural collaborative initiatives in the Working Together project. Undertaking research to understand how Aboriginal and non-Aboriginal health staff understand and experience cross-cultural collaboration was identified by the project-based researchers, workers, and community advisors as a valuable opportunity to document and analyze these insights and experiences.

Method

In recognition of the importance of engaging in ethical and culturally congruent research processes and practices, the research adopted a participatory action research (PAR) methodology (Liamputtong, 2013). The distinctive nature of PAR lies "in its focus on collaboration, political engagement and an explicit commitment to social justice" (Brydon-Miller, as cited in Liamputtong, 2013, p. 181). According to Aboriginal scholar Maggie Walter (2012), PAR is regarded as the preferred social research method employed by researchers who are approaching their work from an Indigenous paradigm. By combining research, education, and action into one process, a PAR inquiry reflects the shared interests of the researchers and the researched community (Liamputtong, 2013).

In this study, the shared interests represented each research participant's experience of cross-cultural collaboration in the Working Together project. At the outset of the research inquiry, the research reference group recognized that engagement in the research process had the potential to provide participants (Aboriginal and non-Aboriginal health workers and community members) with the opportunity to reflect on these collaborative practices to generate insights that could be further integrated into their work. Discussion of the preliminary analysis of the data with the participants also reinforced a methodological commitment that the research findings honor the insights of participants and reflect the importance of ensuring mutual benefits gained from the research (Evans et al., 2009). This reflects a key ethical principle in research conducted with Aboriginal and Torres Strait Islander people.

Ethical approval for the research project was granted by the researcher's university, each of the Local Health District Ethics Committees, and the Aboriginal Health and Medical Research Council of NSW. In Australia, the *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*

(National Health & Medical Research Council, 2003) outline the principles and values that guide research which is undertaken with Aboriginal and Torres Strait Islander peoples. Underpinned by the principles of spirit and integrity, the research ethics submission addressed the values of reciprocity, respect, equality, survival and protection, and responsibility.

Another critical aspect of the research design and process was the need to acknowledge that the coresearchers were insiders. The research was conducted by the non-Aboriginal Working Together project officer and the non-Aboriginal research advisor, who had both played a critical role in a range of Working Together project activities, including project management, training, and resource development.

According to Gair (2012), there is acknowledgment in the research literature of the shifting or fluid, rather than fixed, divide of insider/outsider status, and that insiders (or outsiders) might not all hold the same view or have the same shared experiences (Letherby & Zdrodowski, as cited in Gair, 2012). These issues were taken into consideration and informed the final research design, in particular, the formation of an Aboriginal research reference group and the construction of a four-step process of data analysis.

The Aboriginal and Torres Strait Islander research reference group was established at the commencement of the research process. The role of the group was to provide cultural guidance to the non-Indigenous researchers in areas such as data collection, data analysis, and the dissemination of research findings. In constituting the research reference group, attention was paid to ensuring that members reflected diversity in relation to gender, health disciplines, service delivery contexts, and Aboriginal community backgrounds. To achieve some level of objectivity, reference group members were invited to analyze data from participants who were not colleagues or members of their local community. For a couple of reference group members in particular, participatory engagement involved undertaking with the researchers a range of dissemination activities, including joint presentation of the research findings at international and national conferences and coauthoring research publications. As a result, these Aboriginal health workers developed confidence and skills in research, an outcome that has been documented by other Australian researchers (Hecker, 1997) who have adopted PAR methodology in research with Aboriginal health workers. It also reflects the three key features of PAR:

> First a commitment to social transformation; second, a commitment to honoring the lived experience and knowledge of the participants and community involved; and, third, a commitment to collaboration and power sharing in the research. (Evans et al., 2009, p. 896)

Recruitment

The study was conducted in the Local Health Districts in which the Working Together project activities took place. Reflecting a PAR methodology and the core Aboriginal and Torres Strait Islander research principles of spirit and integrity, inclusivity in the research recruitment process was prioritized. Research information letters and consent forms were distributed via email and through conventional postal processes to each potential participant.

Participants

All ($n = 50$) of the Aboriginal and non-Aboriginal workers who had active involvement in Working Together project initiatives were invited to participate in the inquiry. In total, 41 health workers accepted this invitation, comprising 20 Aboriginal and 21 non-Aboriginal participants, which is a response rate of more than 80%. This strong level of engagement reflected in part the high levels of trust that had been established during the Working Together project between the researchers and their health worker colleagues. An honoring of diverse perspectives and experiences was reflected in the age, gender, and professional backgrounds of the participants (see Supplement Table 1).

There was also a range of diversity among participants in terms of their experiences of working cross-culturally. Prior to their involvement in the Working Together project, many of the non-Aboriginal health workers lacked both training in and professional experiences with Aboriginal people and services. The Aboriginal workers, on the contrary, had varying experiences working with non-Aboriginal workers and services; however, many of these relationships were not ongoing.

Procedure

To maximize engagement, the researchers provided each participant with a choice of data collection methods, including individual face-to-face, telephone, and focus group interviews. Providing this level of flexibility also maximized participation, which, in turn, resulted in an extended period of data collection. Over a 12-month period, a total of 10 individual and seven focus group interviews were conducted. In total, 31 of the 41 participants chose to participate in a focus group interview, with, on average, four to six people attending each of these group interviews. Each interview was conducted by one or both of the non-Indigenous researchers in a range of locations, including meeting rooms in medical centers and hospitals, as well as Aboriginal community controlled medical settings.

The interviews were semistructured and included open-ended questions as well as discussion topics. Each participant was asked to define collaboration, particularly

focusing on personal meanings, interpretations, and purpose of collaboration. Examples of different collaboration processes were encouraged. Exploratory questions were asked, such as "What do you think people need to bring to collaboration?" and "If you were to give some advice to a new worker about the need to start collaborating with other workers and services in town, what would you be encouraging them to do?"

Interviews were digitally recorded (with the consent of participants) and transcribed verbatim. The transcripts were sent back to each participant for verification. Following each interview, extensive reflective memos were written by the researchers. Given the lengthy period of data collection, these memos contributed to the richness of the research process by facilitating ongoing improvements in the interview techniques and processes.

Analysis

In keeping with a PAR methodology and culturally respectful and appropriate research practices, the Aboriginal members of the research reference group were actively involved in the data analysis. In consultation with a number of research reference group members, a template was developed to provide guidance and analytical rigor to the thematic analysis of each transcript.

The analysis was undertaken in four stages. Stage 1 involved reference group members analyzing the transcribed interview data gathered from participants who were not local to the reference group member's health service delivery and community contexts. The completed templates highlighted key themes and concepts which emerged from each interview, including quotes illustrating key themes.

Stage 2 involved the non-Indigenous researchers engaging in a grounded, theory-informed process of data analysis, involving coding, sorting, and organizing the data (Liamputtong, 2013). During this second stage of data analysis, the researchers utilized open, axial, and selective coding processes as well as their reflective memos, which provided additional insights about the data.

Stage 3 focused on comparing, contrasting, and merging the results of Stage 1 and Stage 2 data analysis. The objective was to ensure that the research findings reflected both Aboriginal and non-Aboriginal perspectives. The final stage of data analysis (Stage 4) gave the members of the research reference group and the research participants an opportunity to attend presentations of the research findings which many experienced as illuminating and a powerful endorsement of their work. As a result of this and other feedback gathered at these forums, the researchers undertook additional data analysis. The following section presents the key findings from the inquiry.

Results

The purpose of the inquiry was to identify how Aboriginal and non-Aboriginal health staff understand and experience cross-cultural collaboration. Almost even numbers of Aboriginal ($n = 20$) and non-Aboriginal ($n = 21$) health workers agreed to participate in the study, encompassing a range of disciplines, roles, and organizational contexts (see Supplement Table 1). The results section presents a balanced representation of data generated from both Aboriginal and non-Aboriginal participants.

The section will begin with the definitions of collaboration presented by the participants. Quotes from health workers are identified as belonging to Aboriginal or non-Aboriginal health managers or Aboriginal or non-Aboriginal health workers.

Coming to the Table—Defining Collaboration

Participants were invited to define collaboration. The responses to this initial question generated almost unanimous agreement that collaboration means working together to achieve common goals in ways that are not hierarchical and that build and share strengths and resources: "[Collaboration is] working together and acknowledging our differences, our different ways of doing things to achieve an outcome" (non-Aboriginal health worker). "Collaboration is about working together on an equal basis" (Aboriginal health manager).

The Aboriginal workers emphasized that collaboration is defined by engagement in explicit processes of working together:

> Some people might say that collaboration is if you wrote half a paper and I wrote half a paper and we sent them off together and married them up, that we collaborated on a paper, but did we ever talk? (Aboriginal health manager)

The Aboriginal participants, in particular, were very clear in their understanding that collaboration is very different from consultation. This is an important distinction, given that community consultation is often regarded with skepticism in the Aboriginal community. Collaboration was, therefore, defined as a goal, a way of achieving outcomes, and a process through which new insights, knowledge, and opportunities emerge: "In the spirit of collaboration you might not end up exactly where you first thought you were going to go" (Aboriginal health worker).

Given that the participants were clear about the definition of collaboration, what core aspects of building, maintaining, and sustaining collaborative relationships emerged from the data? These key themes have been grouped under Martin and Mirraboopa's (2003) theoretical framework of Aboriginal ways of knowing, being, and doing. This theoretical framework has been chosen

because it reflects the value position adopted by the Working Together project, of placing Aboriginal world-views at the center of project activities.

Ways of Knowing—Building Knowledge Through Collaboration

According to Martin and Mirraboopa (2003), Aboriginal and Torres Strait Islander ways of knowing entail processes of learning that are social, political, historical, and spatial, taught and learnt in certain ways and at certain times. They are purposeful only to the extent to which the knowledge is used. No one person is able to be completely knowledgeable. Each person has a set of knowledge that fulfills and reflects particular roles. Ways of knowing also take place within networks, groups, and relationships and occur at different levels, in this way contributing to group function.

The research participants engaged with a number of ways of knowing in the process of developing new working relationships with a diverse group of colleagues. These included Aboriginal and non-Aboriginal health care workers, breast care nurses, social workers and health service administrative staff, and managers employed in Aboriginal-controlled medical services, privately run cancer treatment centers, government-run medical services, and nongovernment cancer support services. The Aboriginal workers, in particular, highlighted the importance of forming positive working relationships with colleagues who took the time to listen: "There was a wise old bloke down here, he used to say to people . . . you've got two ears and one mouth; why? He said it means you're supposed to listen twice as much as you talk" (Aboriginal health manager).

Recognition that ways of knowing are also transmitted nonverbally provided Aboriginal workers with insights about the values and attitudes of their potential non-Aboriginal colleagues:

> And sometimes you would be sitting there in silence is key because that silence is them finding out what you're like . . . and they can pick up on body language, if you're not showing the right body language to them. (Aboriginal health worker)

The process of getting to know and understand each other was characterized by the acquisition of knowledge about the local Aboriginal community, its history, language group, and Elders. These aspects of knowing were relevant for all workers, regardless of their cultural backgrounds. The colonized contexts in which this work takes place can be regarded as a potential barrier in the development of collaborative working relationships. Non-Aboriginal workers, in particular, had the potential to become immobilized by their knowing of the history and the contemporary manifestations of colonization, leaving many with a fear of doing additional harm:

> I think for me the project what it's definitely done is taken a lot of the mystique and the fear out of it. I'm certainly a lot happier now to approach Aboriginal medical organizations or Aboriginal health workers you know or just people directly at Aboriginal communities . . . I think I've lost this "oh I'm a white person and I can't go in there." (Non-Aboriginal health worker)

One of the ways in which this barrier was overcome was through Aboriginal workers encouraging their non-Aboriginal colleagues, with whom they had developed trust, to become engaged: "You can become almost handicapped and manacled by being overly aware or sensitive, no matter what the weight of history you need to let the simple heart based stuff of relating" (Aboriginal health manager).

Critical in building trust was developing an awareness of how knowledge is gathered from the community as well as knowing who is a knowledge holder. This required workers to be patient and to proceed slowly and mindfully. However, a different way of knowing about what might work needed to be adopted, a knowing that comes from community knowledge, insights, and experiences: "We just needed to approach it differently, and ask the Elders, ask the community and go in softly" (non-Aboriginal health manager).

Acknowledging that the location and characteristics of Aboriginal knowing can be counter to non-Aboriginal knowledge and evidence can become a source of tension. Managing this tension successfully was particularly critical when new health initiatives were established. The support of team leaders and managers was harnessed to demonstrate active engagement in these new collaborative initiatives. One example is the adoption of new breast care screening schedules, as described earlier, that are sensitive to community commitments and protocols:

> It's a challenge because . . . you've got to bring the executive along with you . . . getting out in the communities . . . with some of our team and that's the only way to do it. (Non-Aboriginal health manager)

However, when organizational commitment is forthcoming, and ways of knowing that reflect the collaborative sharing of ideas, insights, and experiences emerge, communities become engaged with the topic of cancer which was often regarded as taboo when the project first started: "That's where you know that you've been successful because your message is getting out there and you're saying 'Well this is what is happening, this is what cancer is about and you have permission to talk about it'" (Aboriginal health worker).

Transforming service delivery and becoming engaged in joint initiatives also relied on both non-Aboriginal and Aboriginal workers forming working relationships that reflect particular ways of being.

Ways of Being—Building Relationships

According to Martin and Mirraboopa's (2003) theoretical framework, Aboriginal and Torres Strait Islander ways of being refer to processes and experiences that recognize that the self is experienced and constructed in relation to others. This can be demonstrated by workers who have a capacity to recognize that their actions, reactions, and values do not occur in isolation but rather are co-constructed.

One way of getting to know someone required an introduction of the self that was situated in cultural, familial, and historical contexts. The Aboriginal Elder here describes this process, which she also applies to introductions with non-Aboriginal people: "Who they are, where they come from, and what they do in life, what their family does, same as what's in our culture, I would like to know their history" (Aboriginal Elder).

To undertake this process well, non-Aboriginal staff needed to consider how their "White," Western ways of being interacted with Aboriginal ways of being: "As a white Australian, really having a good hard look at yourself in terms of cultural baggage and how that affects the way you relate to Indigenous people" (non-Aboriginal health worker).

For both non-Aboriginal and Aboriginal workers, engaging in this form of cross-cultural introduction process facilitated trust and relationship building. Aboriginal workers, in particular, needed to clarify the potential existence of familial and kinship ties, because these can impact on the nature of the relationships that they will develop with Aboriginal colleagues.

Ways of being also provided a way of understanding Aboriginal help-seeking responses. This was an important area of learning during the project, particularly for non-Aboriginal staff as they tried to identify the reasons why, for example, a lack of engagement with cancer treatment might occur:

> In regards to health and health values . . . there is a difference between how much priority Indigenous people and non-Indigenous people place on appointments and things like that. If there's sorry business going on or cuso (cousin) has just come down from Wello (Wellington) . . . there's so many things that impact because family is such an important thing for Indigenous people. (Aboriginal health manager)

For Aboriginal people, prioritizing individual health treatment and needs can be difficult. Actions and decisions are taken in relation to the needs of others. This can also be understood as a way of being, because well-being is experienced in relation to family and community. Collaborative working relationships provided opportunities to co-construct joint solutions. At times, these processes were characterized by disagreement and conflict between Aboriginal and non-Aboriginal workers, as different disciplinary, organizational, and cultural perspectives collided. Some interesting insights emerged from the data about how these particular ways of being were understood. The Aboriginal workers, for example, normalized conflict as a necessary and inevitable part of the collaborative process:

> From past history anything that we've wanted we've had to fight for and nothing has come easy. Sometimes things have to come to a head to change. We're [Aboriginal people] real good at coping with conflict, we've had to learn to cope with conflict otherwise we wouldn't be where we are today. (Aboriginal health manager)

There was also recognition that conflict was not necessarily well understood or accepted by their non-Aboriginal colleagues, who might personalize these experiences. This could lead non-Aboriginal workers to disengage: "I see it as people debating their ideas, a non-Aboriginal person might see it as they are just arguing all of the time" (Aboriginal health worker).

Managing conflict was, however, an everyday occurrence for many Aboriginal health workers, so these workers have considerable knowledge and strength from which non-Aboriginal colleagues could learn. Some communities "expect you to pick and choose who you talk to and you can't do that. You have to work with everybody, so you do make enemies. But that's just our job. We have to collaborate with everybody" (Aboriginal health worker).

Having the potential to learn and work through these processes was reinforced as both possible and necessary for relationship building to continue. Non-Aboriginal workers recognized that you have to gain credibility in the Aboriginal community, but, to do so, "you have to want to." In addition, you have to "step outside your comfort zone and have a bit of a go." Establishing good relationships with Aboriginal workers was an important step prior to engaging with community. They needed to feel confident that, when they took a non-Aboriginal colleague into a community, he or she would behave in culturally appropriate ways: "She had established respectful working relationships with the Aboriginal Health team and we knew you weren't going to shame us" (Aboriginal health manager).

Collaborative relationships were an important source of support when non-Aboriginal workers were taking a leap into the dark and working in ways in which they lacked

confidence, particularly when working with an Aboriginal community for the first time: "We are here; we're right by your side" (Aboriginal health worker); "[Aboriginal] people have pulled me into the group and eased me through that process" (non-Aboriginal health worker).

Aboriginal health workers also had to gain credibility in a community when they were not of that community: "Some communities are very hard to crack, to get into . . . especially being an Aboriginal person with fair skin and blonde hair" (Aboriginal health worker).

Ways of being that are based on values of reciprocity and mutual commitment were clearly valued and were experienced as personally and professionally transformative:

> Professionally it's made me feel more at peace that I can't always—I won't always—that it's okay to say "I don't know" with other professionals and it's okay to go back to the real basics with the Aboriginal liaison officers and saying "What's the best way to approach this?" (Non-Aboriginal health worker)

Although cross-cultural collaboration required engagement from all workers in particular ways of knowing and being, they needed to be recognized by the Aboriginal community and health care providers as informing effective ways of doing—that is, changes to health care practices that addressed low rates of access to, and utilization of, cancer services by the local Aboriginal communities.

Ways of Doing—Achieving Outcomes

According to this framework, Aboriginal and Torres Strait Islander ways of doing are the culmination of ways of knowing and being (Martin & Mirraboopa, 2003). Ways of doing guide proper forms of conduct, are an expression of individual and group identities and roles, and appear to be a critical dimension of how successful cross-cultural collaboration is demonstrated. They are represented as the ability to change health care practices and perspectives:

> I stood in the car park and patted dogs and you know talked to a few people. But it's all part of the visibility and for people to kind of get used to you . . . and out of that my contact with S [Aboriginal community worker] arose, but for us it is such a different way of working. (Non-Aboriginal health worker)

Adopting new practices, taking the initiative, and being supported by broader groups of colleagues also required support, understanding, and leadership. At times, this was difficult to harness, given that working cross-culturally takes time and requires engagement in different knowledge systems and trust building processes:

> Because of their European orientation maybe, they think that going once and do the consultation and that's it—don't have to go back. They need an understanding that you have to, to follow the protocols, to go back and pay the respect and listen to what the people are saying. You might have to go 20, 30, 40, 50 times. Not just once or twice . . . the managers and the executives and all the rest have to have an understanding. That's the way it works if you're going to work with Aboriginal communities. (Aboriginal health manager)

Critical to these ways of doing was the ability to share power. This can be contested in service delivery contexts, where there is competition for funding and influence. However, when collaborative relationships do strive to be equal, then the Aboriginal community, in particular, becomes more engaged. The leadership that this requires relies on demonstrating honesty with Aboriginal communities. Aboriginal health workers said clearly that, if you make a mistake as a non-Aboriginal worker, you need to own it and then go back to the community. In addition, persistence and perseverance are vital: "I think what we can't do is just say, 'it's all too hard'" (non-Aboriginal health manager).

Some of the characteristics of leaders who were prepared to support cross-cultural relationship building in the Working Together project included the capacity to demonstrate enthusiasm and vision and become visibly engaged. This role modeling sends a critical message to staff and the community:

> It's very, very handy to have a high level person at the meeting. They can make things happen. You've got the workers on the ground and they see this big brick wall whereas we can just cut through and say, "Well, we'll release staff to do this and that." (Non-Aboriginal health manager)

Workers are also mindful of their responsibility to be accountable to their managers for their actions and responses, particularly when they became engaged in the process of collaboratively developing new initiatives: "We have to be answerable to our managers when we go to meetings, so we can't just go and sit there and do nothing" (non-Aboriginal health worker).

This statement potentially highlights a critical difference between Aboriginal and non-Aboriginal understanding of ways of doing. For Aboriginal communities, being there is all important, and the "doing" is in relationship building; but, for some non-Aboriginal people, this can appear to be time wasting or indulgent and unlikely to fit into a non-Aboriginal framework of targets and outcomes. Other non-Aboriginal health professionals, however, were able to recognize that a 5-minute presentation on breast cancer within a 1-day cancer camp was indeed an "investment" and a valuable way of demonstrating to the community their commitment to building trust and relationships.

However, any new health service initiative, such as organizing a cancer camp to enable community members to meet cancer service providers and Aboriginal cancer survivors, needed not only leadership support and endorsement but also resources: "You can't follow through properly and feel like you are giving it hand on heart everything you can give it if you have permission but you have no resources and you're expected to get everything else done" (non-Aboriginal health worker).

Resources for Aboriginal workers mean having the time and energy to ensure that the whole community has an opportunity to be involved. Organizations have to understand:

> Within the Aboriginal community we've got those factions . . . you have to get at least half-a-dozen or more groups together to actually make sure we are giving everyone the opportunity to actually have their input into something, so that takes time . . . it's quite exhausting. (Aboriginal worker)

These new ways of doing were personally and professionally transformative. They provided the workers with a range of new possibilities and capacities in their practices, and this also facilitated sustainable change in the delivery of cancer services: "I think what came out of it for me, personally, is that if I do have someone wanting to talk about cancer that I'd be a lot more confident" (Aboriginal health worker).

Another example of transformative practices was the experience of an Aboriginal health worker who took the initiative when an Aboriginal family was clearly not understanding the implications of what the non-Aboriginal medical team was saying. The confidence she had now developed enabled her to advocate for them; as a result, the patient was able to die at home with family present: "I was a little surprised no one was taking a leading role and I had to step up and say what I said" (Aboriginal health worker).

Similarly, once initiatives are successful and relationships established, community expectations build, and workers recognize the importance of not letting people down: "The more culturally aware you become, the bigger the hat gets" (non-Aboriginal worker).

Discussion

The findings illustrate ways of knowing, being, and doing that need to occur if Aboriginal and non-Aboriginal collaboration is to be successful, in this instance, in providing cancer services. The notion of collaboration is not new but tends to be advanced without clear understanding of its complexity. When the data are analyzed, four particular aspects emerge that provide new insights into the knowing, being, and doing of cross-cultural collaboration. These are as follows: (a) that tension and conflict

are an integral part of collaboration, (b) that reciprocity and respect are important, (c) that sustaining collaboration is a whole-of-organization investment, and (d) that workers experience collaborative work as transformative. These four aspects are now discussed.

Tension and Conflict Are an Integral Part of Collaboration

When we embarked on this research, the term *collaboration* had overtones of working together amicably for a common purpose, and the comments by our research participants certainly support this notion. However, a deeper understanding of collaboration reflects a more realistic perspective, which is that, whenever people undertake meaningful and complex work, there will be differences of opinion. Add into that a history of colonization, dispossession, and racism, and dissension can become highly charged.

Newman et al. (2013) explore the complex terrain of ways health professionals perceive and respond to cultural difference when delivering cancer care services to Aboriginal people. They found considerable discomfort among health professionals about articulating their perceptions of difference or sameness, leading to a tendency to avoid finding a resolution for fear of getting "tangled up in the politics of social inclusion" (Newman et al., 2013, p. 444). In contrast, data from our research show that many workers were prepared to move beyond their fear of making a mistake and into terrain where ways of knowing, being, and doing were unfamiliar. They were able to view the dissenting voice as a means to learn and strengthen working relationships and recognized that it was important not to take criticism personally, but value it as a mark of a genuine relationship and another opportunity to demonstrate commitment to collaboration. True collaboration requires an ability to be able to understand what is happening and why, and to value it as the means to reach better working practices.

Reciprocity and Respect Are Important

Central to the concept of collaboration are reciprocity and respect. Particularly in the early stages of the Working Together project, community asked, "Will you come back?" The message was that community would only engage in the project if the non-Aboriginal participants were committed to seeing through a circular process of consultation, feedback, negotiation, and action.

Taylor and Thompson (2011) use the terms *collaboration* and *partnership* interchangeably and reveal a range of factors that contribute to successful Aboriginal and non-Aboriginal health service collaboration. These include two-way learning and the significance of informally

building relationships. Our data reveal that relationship building encompassed, for the participants (Aboriginal and non-Aboriginal), many hours in communities sitting and yarning, sharing food, answering questions about cancer, and, most significantly, returning with answers. Cross-cultural relationship building was also modeled by some leaders, and this created sufficient safety for workers to step outside their comfort zones and work toward making cancer services more accessible to Aboriginal people.

For such progress to be sustained, the factors that create effective collaboration have to be supported at every level of the organizations involved.

Sustaining Collaboration Is a Whole-of-Organization Investment

Research participants place particular emphasis on the need for organizations to regard relationship building toward collaboration as an investment. Relationship building has to be seen as the precursor to collaboration, and, without relationship building, meaningful cross-cultural collaboration will not occur.

Collaboration necessitates recognition by managers of the time and resources, and the leadership responsibilities that are required to ensure that cross cultural collaboration is supported at every level of the organization. Taylor & Thompson (2011) assert that power imbalances must also be addressed, along with institutional racism which is manifested in the tendency for mainstream organizations to dominate partnership processes. In addition sufficient resourcing and accountability are essential and this includes evaluating both service outcomes as well the effectiveness of partnerships to build collaborations that are based on trust and transparency (Taylor & Thompson., 2011).

Our research participants recognize the importance of relationship building as the precursor to things changing but express concern and frustration that the rhetoric at government level is not translated into realistic support on the ground. Participants strongly asserted that, even though organizations' policies might mandate the creation of respectful, trusting and effective partnerships and collaboration with their Aboriginal communities, this will only come about when they are resourced at every level of the service.

Workers Experience Collaborative Work as Transformative

The research participants felt transformed by being part of effective cross-cultural collaboration. One way of conceptualizing the transformative potential of cross-cultural collaboration is Bhaba's (1994) theory of the third space.

In the third space, two cultures come together and create an intercultural space where new understandings and ways of relating to one another emerge. The intercultural, also known as the in-between, space can be a place of contestation as well as a space where change and new knowledges emerge. Through the inclusion of Whiteness theory and discussions about White privilege (Walter, Taylor, & Habibis, 2011) in the Working Together project cultural awareness training, non-Aboriginal workers were also challenged to understand their own cultural identities and how they impact on their ways of relating to Aboriginal people.

Working in the intercultural space led to long-standing changes to the professional practices and the worldviews of a broad range of Aboriginal and non-Aboriginal health workers (Fronek, 2014). By working closely with Aboriginal colleagues and communities, the non-Aboriginal workers gained confidence in sharing their ideas, concerns, and skills in working directly, often for the first time, with Aboriginal people who have cancer and their families. Aboriginal workers likewise gained confidence in sharing their cultural skills and knowledge with non-Aboriginal colleagues and also information about cancer screening and treatment with their communities.

While both Aboriginal and non-Aboriginal workers felt that their professional skills and practice in cancer services with Aboriginal people had been transformed, non-Aboriginal workers also experienced significant personal transformation. We understand the non-Aboriginal worker's comment "The more culturally aware you become, the bigger the hat gets" to mean that once your eyes have been opened to culture and to the effects of privilege and discrimination, you see it in other aspects of life. Anecdotally, other participants confirmed that having experienced cross-cultural collaboration in Working Together, they now engage proactively with Aboriginal people in their everyday lives and more readily challenge racism and the effects of privilege where they encounter it.

Limitations of the Research

Although this research about cross-cultural collaboration was supported by an Aboriginal reference group, and the data have been jointly analyzed by Aboriginal and non-Aboriginal researchers, the interviews were nevertheless undertaken by non-Aboriginal researchers. We cannot, therefore, know what other insights might have emerged from participants had one of the interviewers been Aboriginal. Extensive distances between interview sites made it impractical for an Aboriginal health worker to be a co-interviewer across all sites. With hindsight, finding a creative response to this limitation, such as ensuring that an Aboriginal participant local to each interview site took a leadership role in interviews, would have strengthened

the research. As was mentioned earlier, the researchers were already known to the research participants. While this contributed to a high participation rate, nonparticipants might have preferred to speak with an "outsider" about collaboration, and the research therefore lacks their views.

Conclusion

To improve cancer health outcomes for Aboriginal and Torres Strait Islander peoples, evidence is needed about "what works, and we need to ensure that such knowledge influences policy and practice" (Garvey et al., 2011, p. 530). For health services, it "requires evaluating what is not working and being big enough to accept that change needs to happen" (Sherwood & Edwards, 2006, p. 189). Providing policy makers with empirical evidence about how health workers develop, experience, and sustain cross-cultural collaborative relationships has the potential to inform policy and practice.

This research has contributed evidence about the role of cross-cultural collaboration in the achievement of critical health outcomes for Aboriginal peoples. The findings indicate a genuine desire for collaboration. This involves engagement with the co-construction of new knowledge and a commitment to relationship building processes. Health professionals practicing in this area need to demonstrate persistence, humility, flexibility, purpose, leadership, courage, and humor. Collaboration involves building solutions with community from the ground up, developing respectful, equal relationships that reflect a willingness to share power.

However, the research also indicates that, when services are struggling to meet many demands, it is critical that the time it takes to build and sustain these relationships is regarded as an investment, from which shared solutions to improving health outcomes can emerge. Working in this way is transformative for workers and services as well as for the Aboriginal community. When they witness Aboriginal and non-Aboriginal people working together, it sends a powerful message that neither of us can move forward without the other.

Additional research needs to be undertaken to understand how cross-cultural collaboration develops and changes over time and how it meets the challenges of tension and difference which are part of any purposeful relationship. Similarly, it is vital to understand more about what contribution cross-cultural collaboration makes to changing health-seeking behaviors for Aboriginal people.

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Declaration of Conflicting Interests

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