RESEARCH ARTICLE

▲ A Model for Large-Scale, Interprofessional, Compulsory Cross-Cultural Education with an Indigenous Focus

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Cultural competency training for health professionals is now a recognised strategy to address health disparities between minority and white populations in Western nations. In Australia, urgent action is required to "Close the Gap" between the health outcomes of Indigenous Australians and the dominant European population, and significantly, cultural competency development for health professionals has been identified as an important element to providing culturally safe care. This paper describes a compulsory interprofessional first-year unit in a large health sciences faculty in Australia, which aims to begin students on their journey to becoming culturally competent health professionals. Reporting primarily on qualitative student feedback from the unit's first year of implementation as well as the structure, learning objects, assessment, and approach to coordinating the unit, this paper provides a model for implementing quality wide-scale, interprofessional cultural competence education within a postcolonial context. Critical factors for the unit's implementation and ongoing success are also discussed. J Allied Health 2014; 43(1):38–44.

CULTURAL COMPETENCE training for health professionals is now a recognised strategy to address health disparities between minority and white populations in Western nations.[1,2] Although considerable debate and critical discussion exist regarding the definition of cultural competence,[3] the theoretical conceptualisation of culture,[4] as well as the benefits and shortcomings of cultural competence training,[3,5] there is general agreement that a one-size-fits-all approach to health service delivery is not appropriate for nations with increasingly diverse populations. Even though structural and institutional factors are important elements of culturally competent care, cultural competence is considered to be integral to developing health care service providers capable of delivering culturally appropriate services.[6,7]

In Australia, developing professionals able to work appropriately and sensitively with Aboriginal and Torres Strait Islanders* has been identified as crucial in the campaign to the "Close the Gap," which aims, through a human rights approach, to create health equality.[6,8] Consistent with other nations with similar histories of colonisation, in Australia there is substantial health inequality between the dominant European population and Indigenous Australians, Aboriginal and Torres Strait Islanders.[7] Whilst the general population has experienced improved health outcomes over the last 50 years, Indigenous Australians continue to be affected by preventable diseases with a 10- to 17-year life expectancy gap.[8] Indigenous Australians experience higher rates of hospitalisation (particularly related to dialysis), cardiovascular disease, cancer, diabetes, psychological distress, kidney disease, injury, disability, communicable diseases, and reduced eye and ear health.[9]

This paper describes an innovative, interprofessional, first-year unit† in a large health sciences faculty in Australia which aims to begin students on their journey to becoming culturally competent health professionals able to provide culturally safe care for Indigenous Australians. Unique in its scale of delivery in Australia, this unit is compulsory for every first-year health science student from the faculty's 22 disciplines and is now taught annually to approximately 2,300 stu-

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*In respect of the diversity of Indigenous Australians, "Aboriginal and Torres Strait Islander" has been used in this paper to refer to the original custodians and guardians of the land which makes up what is now known as Australia. However, at times, "Indigenous Australians" is also used as this is a phrase often found in the literature exploring Aboriginal and Torres Strait Islander cultural competency. The authors acknowledge that many of these terms are contentious and problematic and that some Aboriginal people prefer to be identified by their language group. The authors respectfully apologise for any offence that may be caused.

†"Unit" is used in this paper to denote a short course or program of study which runs for a typical study period over a number of weeks (e.g., fall or spring). In North America, a "unit" is called a "course."

dents. Reporting primarily on qualitative student feedback from the unit's first year of delivery, this paper provides a model for delivering compulsory, wide-scale cultural competency training for emergent health professionals with highly diverse educational needs. Through describing the structure, learning objects, assessment, approach to coordinating the unit, as well as student responses, the paper explores the challenges and critical success factors for implementing wide-scale cultural competency training within a postcolonial context without a loss of quality.

Background

Indigenous Cultures and Health 130 (ICH130)

The unit Indigenous Cultures and Health 130 was introduced in 2011 as part of Curtin University's interprofessional first-year in the Faculty of Health Sciences and was built on the success of an earlier unit from the School of Nursing and Midwifery introduced in 2006.[10] This unit ICH130 was taught to 1,873 students over two semesters in its first year in 2011. The decision to create such a unit and make it compulsory was the result of individual leadership in the faculty and Curtin's broader commitment to a Reconciliation Action Plan (RAP). Reconciliation Action Plans are aimed at improving outcomes for Indigenous Australians through partnerships between Aboriginal and non-Aboriginal people and provide a structure to address key reconciliation issues (relationships, respect, and opportunities) with identified targets within 12-month cycles.[11]

The learning outcomes for ICH130 focus on developing students' understanding of past events and current policies, the social determinants of Indigenous health, and personal reflection as a means to develop their cultural competence. Learning outcomes include:

1) Recognition of the circumstances of international Indigenous populations
2) Identification of the diversity of Australian Aboriginal and Torres Strait Islander peoples and their cultures, and recognition of the significance of cultural awareness, cultural understanding, cultural safety, and cultural security
3) Understanding the association between the impact of policies and history and the current cultural and health contexts of Australian Aboriginal and Torres Strait Islander peoples
4) Analysis of social determinants of health and cultural influences in relation to current health outcomes and the utilisation of health services for Aboriginal and Torres Strait Islander peoples
5) Reflection on their own personal development of cultural understandings as health professionals working in collaborative partnerships with Aboriginal and Torres Strait Islander peoples.

The unit was delivered in 2011 in both fully online and face-to-face mode, with the majority of students enrolled at Curtin's main campus and attending tutorials. Face-to-face delivery of the unit included a blended learning approach with resources available through a learning management system (Blackboard®, Washington, DC, USA). Students enrolled on campus attended weekly 2-hour tutorials over 12 weeks. These were highly structured with Vodcasts (otherwise known as video podcasts) featuring primarily Indigenous Australians "yarning"[12] about issues related to each weekly reading and topic, student group presentations (on the topic of the week), and class discussion (see Table 1).

One of the major innovations of the unit was the inclusion of the Vodcasts which enabled large numbers of students access to authentic learning experiences through hearing directly from a range of Indigenous people about the impact of colonisation, past and current practices and policies, and racism on health and well-being. Using Vodcasts overcame some of the barriers to engaging Aboriginal people to lecture to large groups of non-Aboriginal students, and through the diversity of speakers, many of the commonly held stereotypes of Aboriginal people were challenged.[13] Another significant innovation was the equal and joint co-coordination of the unit by Noongar and non-Aboriginal (Wadjela) staff who model a successful intercultural partnership. Both of the unit coordinators have extensive experience working and teaching interculturally within health sciences as well as a sophisticated theoretical understanding of cross-cultural pedagogy.

The engagement of large numbers of Aboriginal tutors (many of whom were new to teaching) was also significant for the unit's delivery. In 2011, 50% (n=25) of the tutors (50 in total) were Aboriginal. This was a major achievement and was largely the result of community networks and relationships held by the Noongar academic and co-coordinator, who is a highly respected community member and elder. Through engaging a high percentage of Aboriginal tutors in the unit, cultural encapsulation—considered a major barrier to cross-cultural education—was addressed.[14] In other words, students had the opportunity to meet professional Aboriginal people, helping shape an understanding of the diversity of Aboriginal and Torres Strait Islanders whilst providing authentic learning experiences.

Tutors in the unit encouraged and maintained an environment of safety—for all students—to enable many of the assumptions and beliefs (which can be and are often racist) to surface. Teaching in this space comes with considerable emotional labour, which is significant for Aboriginal tutors whose personal and familial identity is at risk from racism in these encounters.[15] Some students, due to their life experiences, move quickly toward understanding the relevance of the unit and its importance to them as health professionals. Other students, however, take longer to move along the continuum of cultural competency, and there are the rare few

Table 1. Weekly Module Topics

Week	Workshop
1	Welcome: Why do we need to do this unit?
2	Introduction to Indigenous Cultures and Health (ICH): Welcome and acknowledgment of country. The difference and why both are so important?
3	Global Indigenous Experience: The importance of language and place
4	Australia's Indigenous People: Why did Australia not have a treaty?
5	Past Policies and Practice: It is documented that over 100,000 Aboriginal children were removed up until 1974. What would it mean to a family if a family member is forcibly removed?
6	The Significance of Identity: The Northern Territory intervention
7	Social Determinants of Aboriginal Health: What does the third space mean to you as a health professional?
8	Family and Community Structure: Discussion of the three social determinants that are specific to Aboriginal people.
9	Social, Emotional and Physical Well-Being: What do you need to keep in mind when working with Aboriginal families?
10	Health Story—Interprofessional Case Study: Health and well-being. What are they?
11	Communication and Working with Community: Examining three Aboriginal Health Organisations—Kimberley Aboriginal Medical Service, Geraldton Regional Aboriginal Medical Service, and Derbarl Yerrigan Aboriginal Medical Service—and discussion of its significance to Aboriginal health.
12	Cultural Safety: What does it mean? Where to from here?

who fail to demonstrate the unit learning outcomes and do not pass. Students who fail are given the opportunity to repeat; however, they are required to pass the unit at their second attempt to continue their studies.

By creating a safe space to speak, tutors of ICH130 support students to engage in a critical discussion on what belief systems underpin their understanding and what lenses they bring which shape (and distort) their knowledge of Aboriginal and Torres Strait Islanders. This, combined with an Aboriginal perspective of Australian history, as well as facts that challenge students' views and the myths about Aboriginal Australians,[16] begins students on their journey to cultural competence by shifting the majority of students' opinions.[17] International students are engaged in the dialogue through reflecting on the history and positioning of indigenous people in their country and through making apparent to all students the relevance and transferability of cross-cultural skills in a global community.

Assessment tasks include a reflective journal, a group presentation framed around key questions for each topic, and e-tests to ensure students have grasped key concepts. The inclusion of a reflective journal as a major assessment task aligns with the fifth learning outcome as well as contemporary cultural competency pedagogy, which emphasises the importance of reflection.[14] Specifically, students were required to create a journal that followed their personal journey through the unit, reflecting on the readings, Vodcasts, workshop activities, documentaries, media and current affairs raised in the workshops or the public arena that relate to global Indigenous populations, and, in particular, Aboriginal and Torres Strait Islander peoples cultures and/or possible health outcomes. The group presentation enabled students to research a particular topic in depth and to work in interprofessional teams. E-tests were aligned with the reading schedule for the textbook.

Cultural Competence in Context of ICH130

The pedagogical approach underpinning ICH130 was informed by the theoretical conceptualisation of cul-

tural competency as a continuum of development,[18] which requires ongoing critical self-reflection. As such, cultural competence cannot be achieved through a single event or encounter,[19] and ICH130 functions as the starting point for the faculty's students on this journey. The history of Australia's development as a nation based on colonisation and the White Australia Policy (where people from non-European backgrounds were excluded from immigrating) has resulted in "whiteness" becoming the neutral or invisible discourse against which all other racial and ethnic identities are measured.[20] For example, when one speaks of ethnic groups, one does not include European Australians; to be ethnic in Australia is to be "other" and this is reflected in education systems, policy, and in every mainstream institution. What this results in is the replication of existing discourses, as power structures remain unchallenged and unchanged.

Effective cultural competency education thus requires individuals (and particularly European Australians) to explore their own racial and ethnic identity and the power and privilege associated with that positioning. This approach is consistent with critical whiteness studies or critical diversity pedagogy which rejects the "embrace diversity" approach for a more sophisticated understanding of underlying power relations embedded in race and identity formation.[21] Embracing diversity uncritically results in a fascination with the "other," reinforcing essentialism and stereotypes, and is characterised by tokenism and exploitation.

Importantly, a key document addressing cultural competence in Australia "Guiding Principles for Developing Indigenous Cultural Competency" was developed in consultation with the Indigenous Higher Education Advisory Council and states "Cultural competence includes the ability to critically reflect on one's own culture and professional paradigms in order to understand its cultural limitations and effect cultural change."[22p3]

As a result of the focus on identity and culture, teaching compulsory cultural competence curricula challenges students and educators alike—particularly those who are from European/Western backgrounds—who are required to acknowledge that the dominant discourses that support and affirm them are culturally specific and represent only one privileged world view. Significantly, the learning experiences were informed by Aboriginal Terms of Reference,[23] which further challenged students' world view. Consequently, teaching Indigenous cultural competence curricula to non-Indigenous students can result in resistance, hostility, as well as feelings of guilt and shame, dependent on the students' existing experiences and racial identity formation. Given the context in which ICH130 is taught, as well as the focus on critical diversity as the theoretical approach, it becomes clear that the delivery of ICH130 to large and very diverse cohorts of students resulting in overall positive feedback is a significant achievement.

Method

The sample analysed here included student feedback data for ICH130 collected in semester one and two in 2011, which was the first year ICH130 was available as part of a suite of units introduced within the Faculty of Health's Interprofessional First Year. The data presented here are from "e*VALU*ate," which is Curtin University's online mechanism for collecting feedback from students on their learning experiences. Ethics approval for the research was granted from the University's Human Ethics Committee.

The data reported here are from the unit survey, which comprises 11 quantitative items and 2 qualitative items. The survey asks students to report their perceptions of what helps them to achieve the unit learning outcomes (items 1 to 7), their engagement and motivation (items 8 to 10), and overall satisfaction (item 11). For each quantitative item, students rate their level of agreement (strongly agree, agree, disagree strongly disagree) or select "unable to judge."[24] The data reported here, however, focus on student qualitative data in response to "comment on the most helpful aspects of the unit" (600 character limit). Feedback from students on "how the unit might be improved" (600 character limit) is provided in the Discussion section of this paper.

Qualitative data comprising students' responses to these two questions were analysed using IBM SPSS® Text Analytics for Surveys 4.0 (IBM SPSS, Armonk, NY). This program creates categories of words and themes based on the number of times (hits) that appear in the dataset. Visual representation can be created (a category web) that illustrates the relationship between categories. The categories appear on the outer edge of the circle with the number of hits in brackets. The lines between categories indicate the association; the darker the line, the stronger the association. All comments were read by the authors to ensure the trends identified through SPSS® text analysis were not methodological artefacts.

Results

The percentage agreement for overall satisfaction for semester one (from eVALUate item 11) was 94% (n=147) and for semester two was 76% (n=598). The lower percentage agreement in semester two reflects some of the challenges related to teaching compulsory Indigenous Australian content to such a large interprofessional group (1,570 students) and the challenges of ensuring consistency between tutors with 50 tutorial groups. The student cohort was smaller and less diverse in semester one, and this likely impacted on feedback. In first semester students were either from nursing, public health, or a generic health sciences degree. Students

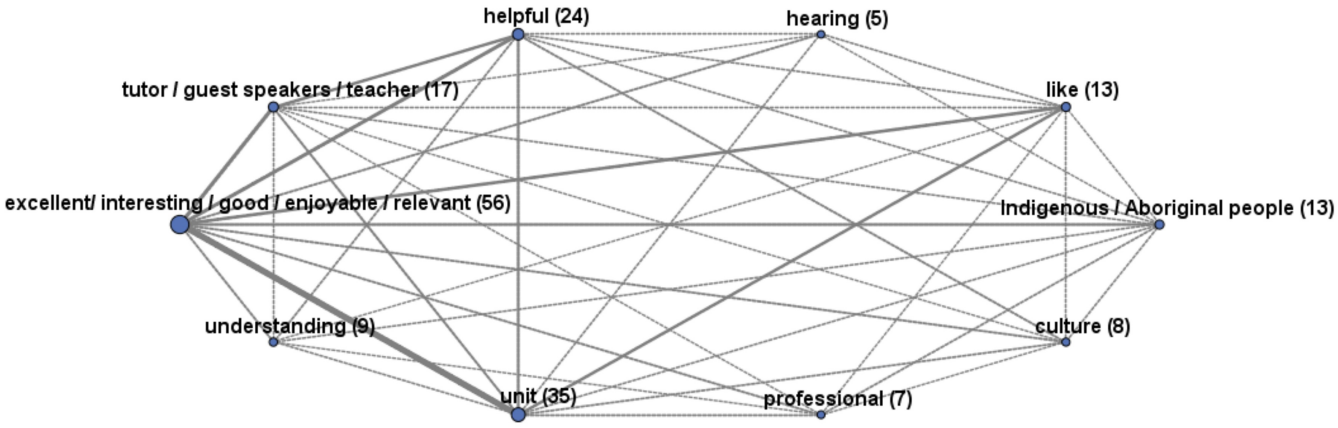

FIGURE 1. Best aspects of ICH130 semester one, 2011.

from these disciplines—particularly nursing and public health—are more likely to appreciate the relevance of this content, as both disciplines would expect to work with Aboriginal and Torres Strait Islander people.

In second semester, students were from 19 different professions, including physiotherapy, pharmacy, generic health sciences, speech pathology, nursing, midwifery, psychology, human biology, oral health, molecular genetics and biotechnology, laboratory medicine, social work, occupational therapy, health information management, environmental health, health and safety, health promotion, and nutrition and food science technology. The first semester was also taught predominately by the coordinators and tutors with considerable experience teaching this content. Due to the large numbers in the second semester, more casual tutors were engaged, and given this was the first year the unit was taught, their lack of experience with the content combined with the range of disciplinary backgrounds of the students probably impacted on feedback.

Best Aspects

Figures 1 and 2 provide a visual representation of student comments pertaining to the best aspects. The strong line between "excellent/interesting/good/enjoyable/relevant" (56 hits) and "unit" (35) for semester one comments (Fig. 2) demonstrates that the majority of students clearly valued the unit and reflects the overall satisfaction percentage agreement of 94%.

Figure 2, representing feedback on the best aspects, is much more complex due to the large number of comments and higher enrolment, but it continues to show that students found the "unit" (n=114) to be "excellent/interesting/good/enjoyable" (n=200,) providing learning experiences which were engaging (n=84). For most students, it appears that the learning experience was "interesting" and "enjoyable," as it provided both new content and a perspective that they had not previously been exposed to: "*This unit was very interesting since I didn't know anything about the Aboriginal culture*" and "*Eye opening & interesting. I was engaged and learnt to let go of previous racist ideas and prejudices. I am now interested in learning more about Indigenous health & culture. I found the vodcasts to be interesting & relevant.*" The Vodcasts featuring different speakers were commonly referred to as "interesting" with students appreciating the variety of voices: "*I feel that my understanding of Indigenous health has been greatly improved, especially because the lectures [Vodcasts] were done by Indigenous people telling us exactly how they feel.*"

The following student comments are direct quotations and illustrate some of the best outcomes:

> *I would like to comment on the fact that the inclusion of this unit into the new curriculum is a great idea. I feel that I have such a new found respect for the Aboriginal culture and people that I didn't have before. I have such a deeper understanding and this makes me so much more motivated and enthusiastic to change and improve Aboriginal health.*

> *This is a very controversial unit, but I think it's essential in helping to beat the inequalities in the Australian health care system. This unit made me notice a change in my attitudes and has really motivated me to work with indigenous people. I liked that we heard from different people each week and think my tutor was absolutely amazing! She was so passionate and was really just able to come down to our level and see where we were coming from and helping us to understand her side of things.*

Discussion

Elements of the learning experience that could be improved are beyond the scope of this paper; however, the primary area identified for improvement was the Vodcasts, which students commented were too long and repetitive. Since 2011, the Vodcasts have undergone editing. The web categories generated in the feedback relating to what could be improved also provide little

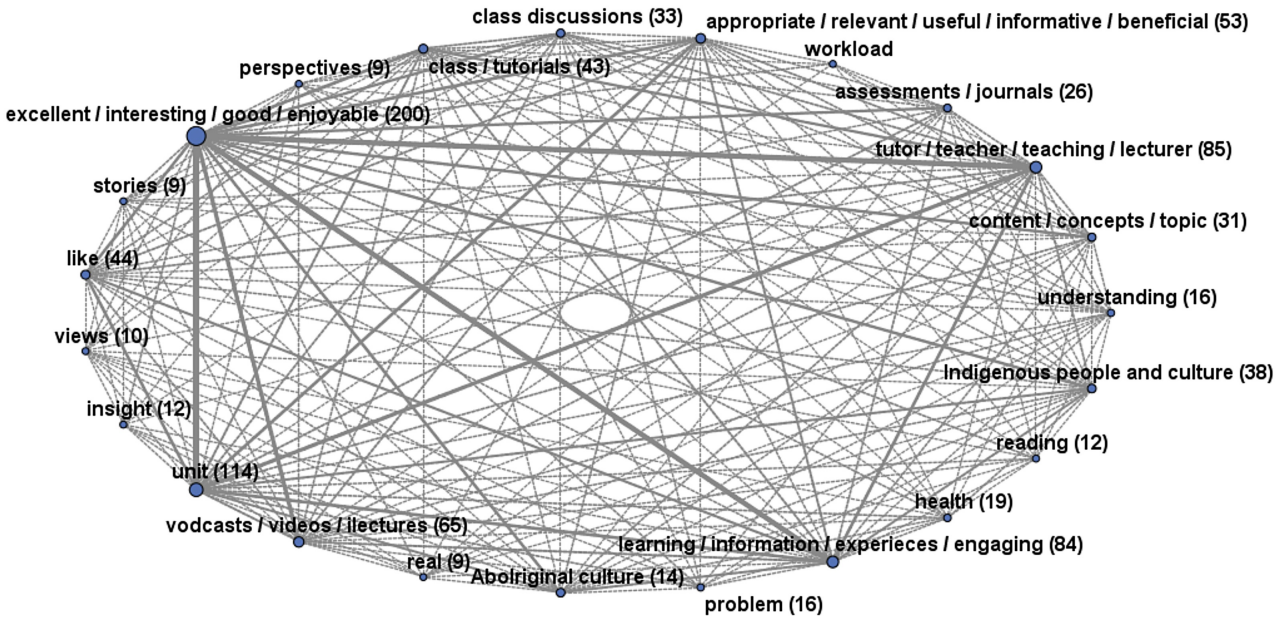

FIGURE 2. Best aspects of ICH130 semester two, 2011.

insight into the challenges associated with teaching and learning in the intercultural space. It is clear from the comments, however, that part of the issue for some students was a cultural divide: a lack of appreciation for the importance of "yarning" as a pedagogical approach in Indigenous Australian culture as well as differences in values, the conceptualisation of time, and approaches to personal interactions. This is one of the likely factors, as many students were also very positive about the value of the Vodcasts (*n*=65), as illustrated in Figure 2.

Other qualitative feedback, typified by the following quote, illustrates that some students struggled and were clearly feeling victimised and blamed: "*I sometimes found the content one-sided, and as a white Australian I sometimes felt like I was meant to feel guilty for things that I hadn't done. I felt it was a tad racist.*" This comment demonstrates the challenges of teaching in this space and this student's progression along the cultural competency continuum. Significantly, Helms' white racial identity model[25] maps a period consistent with this student's feelings of persecution. Helms' six-phase white identify model argues that individuals must move through each phase to achieve a positive collective white racial identity. It is important to remember—and in keeping with the experiences in ICH130—that the achievement of the developmental phases in Helms' model are not given and, when achieved, not necessarily within a consistent timeframe.

Critical Success Factors

One of the major critical success factors has been the leadership of the coordinators and their particular blend of skills, knowledge, and experience of intercultural pedagogy, as well as their cultural knowledge and high emotional intelligence. The teaching team was also exceptional, with some particularly outstanding tutors (including the unit coordinators) who created positive safe spaces for students to explore their beliefs in relation to Indigenous Australians: "*My tutor…was amazing, she made the unit fun and enjoyable and was not judgmental at all*" and "*It was nice to have an open space to discuss opinions without judgment.*" Access to Aboriginal tutors was also highly valued by students and has certainly provided a key learning opportunity: "*Tutorials were fantastic way to engage with my Indigenous tutor and learn his knowledge, and this helps us appreciate Indigenous people and motivate students to achieve and strive in the unit.*"

The following comment is significant and moving, capturing the potential of the transformative learning experience provided. At the same time, it highlights the complex nature of teaching Indigenous Australian content. In response to the question about "how could the unit be improved," one student responded: "*At the moment it is perfect for the main. Not everyone is ready to absorb any more than is offered. The tempo and non-blaming attitude is applaudable. You have survived the unsurvivable, and now teaching the unteachable. Congratulations.*"

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